		For	State of Marylan				l Mental Hyg	giene	10 00001
		State Registrar		Cer	tificate of D	eath		Reg. No. 2 U	12 38001
Physicia		1. Decedent's Name (First, Middle, Last Eddie B.	,				2. Date of Dea	th : 1 ⁰ 5 ^y , 201	3. Time of Death 7:05 р м
Medic Examin		4a. Facility Name (if not institution, give s Laurel Regional H	street and number)		4b. City, Town, or Laur		ath	4c. County o	of Death nce George's
Funeral		5. Social Security Number 6. Se.		ast birthday)	If Under 1 Year	If Under 24 Hi			9. Birthplace (State or Foreign
Director			X M 2 □ F 77	Yrs.	Months Days	Hours Mi	March 7		Country) NC
ind show at	٥Ľ	Usual Residence of Decedent 10a. State 10b. County		, Town or Loc	cation		paren 7	, 1933	10d. Inside City Limits
faryla 8a-f s tified	Director	DC				Washin	gton		1 X Yes 2 □ No
the A	اقا	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
n with ns 232 nust b	Funeral	2700 Jasper Stre	et SE # 154		20	020		United	States
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene are stated on the Health and Hygiene. Department of Health and Health and Health and Health and Hygiene. Department of Health and Heal	by	11. Marital Status 1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	l I	Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 🔀 No	n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		- American Indian, s, White, etc. African American
hour	Completed	15. Decedent's Ed (Specify only highest grad	ucation		lent's Usual Occupa			16b. Kind of Bus	
hin 72 ne. Ihan "	mo	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	of work done done done done done done done done			0	
d with	Be C	8th 17. Father's Name (First, Middle, Last)		Foc	od Service				vernment
l be file lental l rked o tic eve	일	17. Fatter S (value, East)			unk.	18. Mother's N	ame (First, Middle, I Alice H		
should and M is ma		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (Street a	nd Number or F	Rural Route Number	City or Town, Sta	ate, Zip Code)
nd 2 sealth m 27		Diane Hall - Daug	nter	3836	South Car	pitol S	treet SE	# 202 WI	OC 20032
or off		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐			sition (Name of natory or other place) Oct	. ^{Date} 0,		City or Town, State
it. Pag rtmen rtant: njury		4 Donation 5 Other (Specify	Le		rematory	_	2012		ton, Maryland
permit Depar Impor any in			manta	4(001 Benni	ng Road	tewart Fu NE Wash	ington,	
Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.		er the mode of dying			est,	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
N. S.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. HYPERTE		e cha.	PNIDIC	OF MICTY		
ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
e exectian ar	al E	resulting in death) Last	Due to (or as a consequ	ence of):					
ate be	edical		d						
eath certificat attending ph	/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of pregnal	ncv				20d Date	- E - I-line
Attending Physician: The law requires that the death certificate be executed redering Physician. The law requires that the death certificate be executed ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)	/		Mon	e of delivery th Day Year
s that gned k	by	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the u	nderlying cause give	en in Part I.			bute to the cause of death?
equire een si nould	ted						_ 1 🗆 1		3 Probably 4 Unknown
The law r cate has b	Completed						24a. Was a autop perfor 1 Yes	rmed? pr	lere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hospital:		Othe	ce of Death (Ch			
y Physer this eral d	e: <u>T</u> o	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	t 3 L DOA 28c, Injury	4 LI Nursing	Home 5 Resid	ence 6 Dother	
ath. r: Afte	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 🗆	Yes 2 No		,,	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)		eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
the Hosp nin 24 hou the Funer npletely fil	Medical	(Check 2 Medical Examin	ician: To the best of my knowle er: On the basis of examination e Practitioner: To the best of m	and/or invest	igation, in my opinio	n, death occurre	d at the time, date a	nd place, and due	to the cause(s) and manner stated.
North		29b. Signature and title of certifier	8	_	29c. License				(Month, Day, Year)
45m				10		1264		10/20	5/2012
		30. Name and address of person who co				7171	~ 1 V = 1 ~ W /	n n-n	~~7
Stat	e	31. Date filed (Month, Day Yes) 2012	432. Registrar's Sign t		6 J 31E	220 C	WREL, W	ns 101	01
Registra	ar	MOA A STAIS	Alagua p.	The same					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2012 3:25 A M Helen LaRue Hitchens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Washington Homewood Retirement Center If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min May 18716 Pennsylvania 188-20-9313 96 1 □ M 2 🛛 F Director Yrs Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland other than "netural", or items 23a or 28a-f sho Director 1 ☐ Yes 2XXNo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important if item 27 is marked other them. eny injury or other treums**-21795 16505 Virginia Ave. B217 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hitchens Edna Pearl Rorabaugh Harry Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20110 Mt. Aetna Rd. Hagerstown, Maryland 21742 Donald L. Reeser - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 4 ☐ Dopation 5 ☐ Other (9) Bernoval from State Duvall Cemetery Nov.12,2012 Six Mile Run, PA Osborne Funeral Home, P.A. . Signature of F 22. Name and Address of Facility 425 S. Conococheague St.Williamsport,MD 21795 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any cause immediates cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner Due to for as a consequence of ed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months
1 ☐ Yes 2 ☐ No Month g 🗌 Unknown 9 Unknown signed by t Part It: **Qther significant conditions** contributing to death but not <u>res</u>ulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been significate has been significated and a should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 770 1 ☐ Yes 2 ☐ No Yes 2 -25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 🗆 Yes 2 🗆 No injury 5 Pending 24 hours after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical To the Hosp within 24 hou To the Funer completely fi 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only ong 29d. Date signed Month, Day, Year

State Registrar

JW-3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give str **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ente 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs **Funeral** 1 □ M 2 🗓 F March 3 Months Hours 46 213-72-8469 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f sho with the Maryland must be notified at Director 1 🗆 Yes 2 No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ by Funeral **23**a U.S.A. 21742 13106 Orchid Dr. items 2 Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) State Government Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Mary Helen Wilburn Lanny Roland Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary H. Harris-mother 18747 Mesa Terrace Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If itel
any injury or oth 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 11-7-2012 Smithsburg, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory. List only one cause on each line.
Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No s been signed by the s should be detached 9 Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I page 2 s autopsy perform 1 ☐ Yes 2 🕱 No 1 Yes 2 No this certificate Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, ၉ 1 Yes 2 No 1 🖫 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 28c. Injury at work? 1 □ Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: After injury 1 X Natural 5 Pending within 24 hours after death.

Jo the Funeral Director: Af Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [within 2 Jo the F the only one)

Registrar

State

29b. Signature and title of certifie

30. Name and address of person

31. Date filed (Month, Day Year)

ompleted cause of death (Item 23a) (Type, Print)

egistrar's Signature

Bridgette

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4756 Willows Road, Chesapeake Beach, MD

Nov. 6.

2012

8200 Jennifer Lane, Owings,

22. Name and Address of Facility Lee Funeral Home Calvert, P.A.

Flannigan

20c. Location - City or Town, State

Clinton, Maryland

Approximate Interval Between Onset and Death

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

Examiner

Funeral

Director

/Medical

10a. State

Directo

Funeral

Completed

Be

ဥ

Arthur

20a. Method of Disposition

Immediate Cause (Final

disease or condition resulting in death)

19a. Informant's Name/Relationship (Type. Print)

4 □ Donation 5 □ Other (Specify)

21. Signature of Funaral Service Licensee

23a. Part1. Enter the disease, or comeshock, or heart failure. List only

Patricia Finnegan - Daughter

1 ☐ Burial 2 【X*Cremation 3 ☐ Removal from State

O'Donnell

NOV - 5 2012 Genera B. Jacks

Physician

Division or Vital Records, P.O. Box 68760,

w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
The law requires that the death certificate be the has been signed by the attending physicianage 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 monums? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pred Other (spec			23d. Date of de Month	livery Day Year
equires that en signed b ould be deta	by	Part II. Other significant conditions	contributing to death but not resulting in the ur	nderlying cau	ise given in Part I.	23e. Did tøbaco		o the cause of death?
The law re cate has be- page 2 sho	Completed					24a. Was an autopsy performed 1 Yes 2	? prior to death?	utopsy findings available completion of cause of s 2 □ No
striffic ctor,	Be (25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)		
nyslo nis ce dire	10	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA	Other: 4 Nursing H	lome 5 ☐ Residence	e 6 ⊟Other (Spe	ecity) ALF
ath. or: After the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		M 28	c. Injury at Work? 1 Yes 2 No	28d. Describe how in	njury occurred	
tal or Atters of all Directors of in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		eet, factory,	office	28f. Location (Street City or Town, St	and Number or Fi tate)	ural Route Number,
To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 v.	Medical (29a. Certifier (Check only one)	hysician: To the best of my knowledge, death miner: On the basis of examination and/or in and manner stated.	occurred a vestigation, i	t the time, date and place n my opinion, death occi	e, and due to the cause urred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
To the Com	Ž	29b. Signature and title of certifier	A		License number	29d.	Date signed (Mon	th, Day, Year)
		> pu m	1/1		0073574	11	13/10	1
KW		1/2 /// /// 1	completed cause of death (Item 23a) (Type, ILLOV9 PEOV VE/E)	Print)	nevy h	Willersn	lle m	p 21108
		21 Date filed (Month Day Vees)	22 Pagistror's Cignature					

20b. Place of Disposition (Name of cemetery, crematory or other place)

explications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Lee Crematory

Registrar

State of Maryland / Department of Health and Mental Hygie	,	State o	f Maryland /	Department	of He	ealth and	d Mental	Hygien
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			for State of IVIS	aryiand / Depa <i>Cer</i>	artment of F tificate of D			gierie Reg. No.		
ı	Physicia		Decedent's Name (First, Middle, Last) PETER JORET HENDERSON	1			2. Date of Dea Month October		20 ^{Yea} 2	3. Time of Death 4:24pm M
1	Medic Examin		4a. Facility Name (if not institution, give street and number) 23530 Frederick Road		4b. City, Town, or Clarks	Location of Death		4c. Col	unty of Death	J
	Funeral	-	5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	h y, Year)	9. Birth	olace (State or Foreign
i.	Director		218-66-8257 1 M № 2 □ F Usual Residence of Decedent	57 Yrs.			July 2	6,1955		ifornia
	laryland 3a-f sho ified at	ector	10a. State 10b. County Maryland Montgomery	10c. City, Town or Loc					1	0d. Inside City Limits 1 ☐ Yes 2X No
	h the N 3a or 28 be not	al Dir	10e. Street and Number 23530 Frederick Road		10f. Zip Code 208	71		-	of What Cour	
	eath wil tems 2: er musi	Funeral Director	11. Marital Status 12. Was Decedent E		Vas Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. [State Race - Americ	an Indian,
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Fyes 2 If Yes, Size Year or Dates.	No	f Yes, specify Cubar		Hican, etc.)	Spei	Black, White, cify: Wh	
Baltimore, Maryland 21215-0036	nin 72 hou ne. han "natu e Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	(Give i	dent's Usual Occupa kind of work done d O NOT use retired) ck Driver	luring most of work	ing		of Business/In	-
ind 21	e filed with tal Hygier ed other t event, th	To Be C	12	1140	JR DIIVEI	18. Mother's Nam	ne (First, Middle, Marie Jo	Maiden Surn		***************************************
aryla	hould be and Mer s marke umatic		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a	and Number or Run	al Route Numbe	r, City or Tow		
e, M	and 2 s Health a tem 27 i		Maria T. Henderson (Ex-Wife 20a. Method of Disposition	20b. Place of Dispo	B Demetri	as Way ,	Germant		MD 208 on - City or To	
imor	Page 1		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren	natory or other place. e Cemeter		12,		ille, N	
Ball	permit Depart Impor any in		21. Signature of Funeral Service Litensee (MO)		Name and Addres Deast De					D 20877
j	and the second		23a. Part J. Enter the disease, or complications that caused shock, or fleart failure. List only one cause on each line Immediate Cause (Final	b.	er the mode of dying	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition ASPITA	tion a consequence of):						
	LAMIIIICI	ner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying. Beginning GI Blee	eding a consequence of):						
	and and and and	xami	Cause (Disease or injury that initiated events Gastric	c/Duodenal	ulcers					
90	e death certificate be executed the attending physician and hed for use as the burial transit	edical Examiner	,	c Alcoholis	sm					
9	certifical nding ph use as t		IF FEMALE: 23c. If yes, outcome	of pregnancy	7	 -		23d.	. Date of deliv	ery
Box Hox	is that the death certi gned by the attendin be detached for use	Physician/M	in the past 12 months? 1		Ectopic pregnanc Other (specify)	y 			Month	Day Year
ν. Σ.Ρ.	To the Hospital or Akending Physician; The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact.	ρ	Part II. Other significant conditions contributing to death b Chronic Smoking	ut not resulting in the u	inderlying cause giv	ren in Part I.				ne cause of death?
2602	lay requises been 3.2 shou	Completed	Hypertension				24a. Was	osy	prior to co	psy findings available mpletion of cause of
Re	an; The tifficate h tor, page	Be Cor	25. Was case referred to medical		26. Pla	ace of Death (Chec	1 🗌 Yes	ermed? 2 👿 No	death?	2 🗆 No
Vita	hysicia this cer al direct	욘		ent 2 ER/Outpatier	nt 3 🗆 DOA Othe	er: 4 Nursing H	ome 5 🕅 Resid)
91 O	ath. r; After	icate	27. Manner of Death 1 Natural 2 Accident 5 Pending 1 Investigation	ry 28b. Time of injury	work	≀at ? Yes 2 □ No	28d. Describe h	ow injury occ	curred	
Pivisi	al or Arters after de safter de il Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	iry - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (S City or Tow		mber or Rura	Route Number,
3A. K	e Hospit 24 hour e Funera letely fills	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examiner) only one) 3 Certifying Nurse Practitioner: To the	xamination and/or invest	tigation, in my opinio	on, death occurred a	it the time, date a	ind place, and	due to the ca	use(s) and manner stated.
7	withing the second of the seco	2	29b. Signature and title of certifier		29c. License	number		29d. Date sig	gned (Month,	Day, Year)
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type. F		07232	7	Noveill	ber 1,	2012
			Dr. Raghuram Chava 18101 P	rince Phil	ip Drive,	Olney,	MD 2083	2		
	Star Registra		31. Date filed (Month, Day, Year) NOV 0 2 2012	ar's Signature	les.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38006 State
RegistraMEND#23a(b)perMD,11/2/12;BMN,Mcco Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Oct. William Hanford 2012 26 8:55 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5613 Overlea Road Rethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Days Hours 127-36-6879 Director 1 X M 2 □ F 71 May 21,1941 Delaware 28a-f show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 X Yes 2 No Montgomery Bethesda ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5613 Overlea Road 10708 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 K Married δ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: Completed 3 Wildowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) should be filed within 72. h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Business Law Science Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Edward Hanford, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke any injury or other traumatic Lorraine Easom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mona M. Hanford/Wife 5613 Overlea Road Bethesda, MD 20816 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State Metropolitan Crematory Oct. 26, 4 ☐ Donation 5 ☐ Other (Specify) Alex., Virginia 21. Signature Fune al Service 22. Name and Address of Facility DeVol Funeral Home MO1315 2222 Wisconsin Ave., N.W. Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician. Debility disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Comorbidity of senile dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of) Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death Physician/ 23b. Was decedent pregnant 23d Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant Pregnant at time of death 5 Other (specify) Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed ral director, page 2 should be de <u>ج</u> 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No 1 ☐ Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: ဂ္ 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ₺ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural Accident 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Jocelyne Kouatchou, m) D63748 24

State Registrar 4041 Powder Mill Road #600 Beltsville, MD 20705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Sign

Jocelyne Kouatchou, MD

NOV 02

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Idoni, Sr. Frank Leonard Month 3:40 ДМ November 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 28,1931 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 236-48-3286 81 **Director** 1 X M 2 F Maryland I hygiene. other than "natural", or items 23e or 28e-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 X No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 14616 Cutstone Way USA permit. Page 1 end 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Importent: if item 27 is merked other than "natural", or items any fujury or other treumatic event, the Medical Examiner mu 9008. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☑ Yes 2 ☐ No 1952-Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify specify: White 3 Widowed 4 Divorced If Yes, Give Completed 1954 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highe (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Α. Torchia Domenico Μ. Idoni Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 14616 Cutstone Way, Silver Spring, Maryland 20905 Wife Jacqueline Frances Idoni, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/7/2012 Glen Burnie,Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Cole Funeral Services, P.A. 4110 Aspen Hill Rd.,#100,Rockville,MD 20853 23a. Part 1. Enter the discusse, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Prostate Cancer, Stare 4 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sersis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Atrial Fibrillation sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s 1 Yes 2 No I ☐ Yes 2 🛣 No Division of Vital 25. Was case referred to medical director Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Other: 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after death.

e Funerei Director: After th

letely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospitei o within 24 hours af To the Funerei Di completely filled is Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) D0073240 November 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 1500 Forest Glen Road, Silver Spring, MD 20910 Anisha Kumar, MD 31. Date filed (Month egistrar's Signatur State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2334 Physician/ Month 70HW50N Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10n topmen ethes RNMI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fo Security Numbe 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Year) 550-28-4522 1 □ M 2 1 € Director 89 03/23/1923 Idaho and 2 should be filed within 72 hours after death with the Maryland Fleath and Mentel Hygiene. It is merked other then "natural", or items 23e or 28e-f ahov other traumetic event, the Madical Examiner must be natified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Potomac 1 Yes 2 No Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20854 United States Funeral 11105 Bellavista Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 √ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Baciu Maria Vintilo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5707 Ridgefield Road Bethesda, MD 20816 f Health Steven Curtis Johnson / Son-POA or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10/31712 permit. Page 1 a
Department of I
Important: If ite
any injury or of Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cemet. Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons LLC. 5130 Wisconsin Avenue NW Washington, DC 20016 -M00063 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause in each line. Onset and Death Immediate Cause (Final Physiciani DEDSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-thest Exami To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and 'completely filled in by the funeral director, page 2 should be detached for use as the burial: tasel. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pionths? Month Year 5 Other (specify) Day Pregnant at time of death g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed; 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 잍 Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifie 0 201 1074 153

Registrar

State

31. Date filed (Month/Day, Year)

OCT

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 01.29AM ROBERTA JUCHNEWICZ OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY KOSPITA OLNEY MEDSTAR MONTGOMERY If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number . Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) 119-32-3567 72 **Director** 1 □ M 2 □XF July 2, 1940 Usual Residence of Dece 23a or 28a-f show 10d Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified at 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 20906 15115 Interlachen Drive, Apt. 506 USA or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ※XXXo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black White etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daniel Robert Bullwinkle Bertha Staebler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10401 Carraigepark Court, Fairfax, VA 22032 Richard A. Juchnewicz/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial XXX Cremation 3 ☐ Removal from State Nov. Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licenses Name and Address of Facility Home Inc. Francis J. Collins Funeral
500 University Blvd. W. Si

23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Francis J. Collins Funeral 500 University Blvd. W., S MD 20901 Approximate Interval Between Onset and Death Acute on dironic Ry Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any local group resolutions cause. Enter Underlying Cause (Disease or injury Examiner B To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Live Birth ∠ ☐ regnant at time of death ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 🔀No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: A Investigation 6 Could not be __ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined

State Registrar

Completely fit

Medical

29a. Certifier (Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Dr, Olney MP 2083Z RAGNURAM CHIVA, MEDSTARMONTGOMERY GENERAL MOSPIT 31. Date filed (Month, Day, Year) 02 NOV

MI

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0072328

29d. Date signed (Month, Day, Year)

November 1st 2012

GENERAL MOSPITAL

29c. License number

			for State Registrar	State of N	Maryland /	Department of I Certificate of L			2111	2 38010
	.		1. Decedent's Name (First, Middle	, Last)		00/11/10010 0/ 2	200177	2. Date of De	ath	3. Time of Death
	Physicia Medic		Mildred Louise					OMonth	BE 2 3 20	10.101
	Examir	ner	4a. Facility Name (if not institution			4b. City, Town, o	Location of De	eath	4c. County of I	A 0
-	Funeral		5. Social Security Number		ge (In yrs. last bin	thday) If Under 1 Year	If Under 24 F	Irs. 8. Date of Birl	TADHE	Birthplace (State or Foreign
	Director		577-24-6129	1 □ M 2 XX	89	Yrs. Days	Hours M	1in. <i>(Month, Da</i> 8/26/1	y, Year)	Country) DC
	nd how at] =	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location		0/20/1	723	10d. Inside City Limits
	Maryla 18a-f s tified	rect	MD Anne	Arundel		Crowns	ville			1 🗆 Yes 🕱 🛣 No
	h the la or 2 be no	Funeral Director	10e. Street and Number		•	10f. Zip Code			10g. Citizen of Wha	
	rth wit ms 20 must	ner	354 South Rive		- 110	Law a second	21032			SA ————————————————————————————————————
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 □ Never Married ※ Marriad 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2X If Yes, Give Year or Dates.	?	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2★★No		(Specify Yes or No- lerto Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
77.	72 hou "natu edica	plet		t's Education st grade completed)	16a	. Decedent's Usual Occup (Give kind of work done of		working	16b. Kind of Busin	ess/Industry
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Maryland	Menta Menta narked	ပ	Charles Watson				Vio	la Thomps	on	
Nar	shou hand 7 is m traum		19a. Informant's Name/Relationsh			Mailing Address (Street a			•	
	Healt Healt Hem 2	, 1	Dale Kepner 20a. Method of Disposition	Husband		4 South River f Disposition (Name of	erside l	Drive C	rownsville 20c. Location - Cit	e, MD 21032
ШO	Page 1 nent of int: If i		1 🏿 🕱 urial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 Removal from State	e cemete	ry, crematory or other place .nd Veterans		11/5/2012		
Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Service L		mary ra	22. Name and Address 12 Ridgely	ss of Facility H	ardesty F	uneral Hors, MD 210	me, P.A.
	Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as	a consequence of	of):	g, such as card	liac or respiratory arr	est,	Approximate Interval Between Diset and Death
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of Vital	ysician: s certific director,	To Be	examiner? 1 Yes 2 No	Hospital:	ient 2 TER/Ou	tpatient 3 DOA Othe	ace of Death (Co		lence 6 Other (S	
Division of	ttending Ph death. tor: After thi y the funeral	Certificate: 1	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could r 4 Homicide determine	28a. Date of inju (Month, Date ation of be	ury 28b. T ay, Year) ir	ime of 28c. Injury	at	28d. Describe h	ow injury occurred	Rural Route Number,
ΟĬ	pital or A ours after eral Direc filled in by			building, et	c. (Specify)			City or Tow	n, State)	
	To the Hospital within 24 hours: To the Funeral I completely filled	Medical	(Check 2 L Medical E	aminer: On the basis of a	examination and/o	vladga, daeth chourned et ti	n, death occurre	ed at the time, date and place, and due to the	nd place, and due to the Cause(s) and main	the cause(s) and manner stated.
D	75. 5 1 5 8	2/0	CHA	BATO	M	29c. License			29d. Date signed (MC	onth, Day, Year) 1 31 2012 MU 20161
	XX		30 Name and address of person v	B Completed cause of	leath (Item 23a) (1	ospital d	drue	Glen	Bulmip	MU 2016
	Stat Registra		31. Date filed (Month, Day, Year) NOV 0	2012 32. Registr	rar's Signature	pare				

DHMH 17 Rev 06-2011

		4	For State	State of Ma				and ivi	ental Hyg	giene		
			RegistAMEND#18+19boer 1. Decedent's Name (First, Middle, Las		W,MoCo (Certificate	or Death		2. Date of Dea	Reg. No.	12	Tating of Party
	Physicia	n/		initis					October		1 ^{Year}	6:55 am
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, To	wn, or Location			4c. County		
			Montgomery Hospi				kville				tgom	
	Funeral		5. Social Security Number 6. S		(In yrs. last birth	Months [Year If Under Days Hours	Min.	8. Date of Birt (Month, Day	h , Year)	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	Dgm 2 □ F (59 Y	rs.			Dec. 6,	1942	PA	
	f sho	ţċ	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits 1 ☐ Yes 2x X No
	a Mar	Director	MD Montgo:	mery	Tako	ma Park	ode		· 1	10g. Citizen of	What Cou	
	23a o	rai	407 Tulip Avenue	Ant 204			20912			USA	What oou	muy.
	eath v	Funerai	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Deceder		rigin? (Spec	ify Yes or No-	14. Rac		can Indian,
36	"or i	ا۾	1 Never Married 2 Married	Arroed Forces? 1 2 Yes 2 1 N If Yes, Give		1 Yes 2			ilicari, etc.)	1	ck, White, :Wh1t	
Ö	ours eatural	Completed	3 Widowed 4 Divorced 15. Decedent's E	Year or Dates. 1		Decedent's Usual (Occupation			16b. Kind of B		
215	n 72 h L Ban "n	립	(Specify only highest gr Elementary/Secondary (0-12)			Give kind of work of ife. DO NOT use re	done during mo	st of workin	g	102.1411.001.2		,
2	yglane yglane her th	اما	12			operty M	anager			Se1	f-Em	ployed
and	ntal H	일	17. Father's Name (First, Middle, Last) Joseph Kurtiniti				Miri	her's Name am	(First, Middle, anderbu	Maiden Surnam	ie)	
Ž	ould by Many Mark		19a. Informant's Name/Relationship (7		19b.	Mailing Address (S		-			State, Zip	Code)
ž	d 2 sh alth au 1.27 is er trαu	П	Jennifer Kurtin	itis/Daught	er 40	7 Tulip	Avenue,	Apt.	204, 7	Cakoma I	ark,	MD 20912
Baltimore, Maryland 21215-0036	permit. Paga 1 and 2 should ba filed within 72 hours after death with tha Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	П	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑	Removal from State	cemeters	Disposition (Name , crematory or oth	er place)	00+	ate . 31,	20c. Location	- City or T	own, State
ij	t. Pag tmant rtant: Nury c		4 Donation 5 Other (Speci	ify)	West Pi	ttston C		2	012	West Pi		on, PA
Bal	parmit Dapar impor any in		21. Signature of Funeral Service acen	see		Francis						MD 20901
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do no	500 Uni	of dying, such a	is cardiac or	respiratory an	rest,	ring	Approximate Interval Between
,f	Pnysician/		Immediate Cause (Final disease or condition	Colon Car	ncer							Onset and Death
-	Medical Examiner		resulting in death)		consequence of):						
		Je.	Sequentially list conditions,	b. — Due to (or as a	consequence of	n:					\rightarrow	
	Wast Trad	edicai Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
	cata be axecuted physician and s the burlai-transit	Ē	resulting in death) Last	Due to (or as a	consequence o	f):	-					
9	ata ba ohysic tha bu	dica		d					-			
687	ding g		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			- T			23d. D	ate of deliv	very
Box 687	a attar	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown		3 Ectopic pro				м	onth	Day Year
P.O. E	or Attending Physician: The law requires that the death certific infer death. Director: After this certificate has been signed by the attending F in by the funeral director, page 2 should be detached for use as	Physician/M	9 Unknown Part II. Other significant conditions		rt not regulting in	the underlying ca	use diven in Pa	rt I	220 Did t	abacco use con	tribute to	the cause of death?
œ.	as the signac d ba d	d by	Part II. Other significant conductions	contributing to death be	it flot resulting if	i ino undonying od	adoc giveiriir i					obably 4 🖺 Unknown
Division of Vital Records,	raqui baan should	Completed							24a. Was	an 24b.	Were auto	opsy findings available
ecc	Tha law cata has I paga 2 s	E O							auto perfo 1 🗆 Yes	ormed?	death?	ompletion of cause of
alF	ılclan: Tha cartificata ıractor, pag		25. Was case referred to medical examiner?				26. Place of D		only one)			
N N	hysic this ce al dira	မြ	1 ☐ Yes 2 ☑ No 27. Manner of Death			tpatient 3 DOA				Ho dence 6⊠ Ot		e fy)
n o	ding F h. Aftar funar	Certificate:	1 Accident Investigation	28a. Date of injur (Month, Day		ine of 280 ijury M	c. Injury at work? 1 \Boxed Yes 2		28d. Describe I	now injury occur	теа	
isio	Atten ar daat ector: by the	Ě	3 Suicide 6 Could not	be 28e. Place of Inju		m, street, factory,		_			ber or Rura	al Route Number,
Θ	Ital or irs afte al Dir			building, etc					City or To			· ·
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartification of the Funeral Director of the Funeral director.	Medical	(Check 2 Medical Exam	ysician: To the best of on niner: On the basis of ex rse Practitioner: To the	amination and/or	r investigation, in m	v opinion, death	occurred at	the time, date	and place, and d	ue to the c	ause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 2 Certifying Nu 29b. Signature and title of certifier	rse Practitioner: 10 the	best of my know		License numbe		os, and due to	29d. Date sign		
	10+		De Storah	Multo	CR	NP R	143201			10.2	7.1.	2
	,		30. Name and address of person who									
			Debrah Miller, 31. Date filed (Month, Day, Year)		Piccar	d Drive,	Rockvi	lle,	MD 2085	0		
	Sta Registi		OCT 31 20		1.	backer						

			_ For	Department of Health and M	Mental Hygiene
		_1	1 - State Registrar	Certificate of Death	Reg. No. 2 0 1 2 3 0 0 1 2
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Last) VOHN FRANCIS KIERNAN		2. Date of Death Month Day Year / 5:30 M
7	Examin	or	4a. Facility Name (if not institution, give street and number) Med Star Montgomery Medical Cent	4b. City, Town, or Location of Death	4c. County of Death MONTGOMERY
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 181–18–9502 1 May 2 F	irthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	-1		Usual Residence of Decedent	Yrs. wn or Location	Dec. 22, 1923 NY
	laryland 3a-f sh ified at	Director		Silver Spring	1 ☐ Yes 2 🖾 No
	vith the N 23a or 28 st be not	eral Dir	10e. Street and Number 2921 North Leisure World Blvd.,	10f. Zip Code	10g. Citizen of What Country? USA
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates. WWII	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	acify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. White Specify:
15-0	72 hour n "natu 1edical	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Business/Industry
212	within ygiene.		Elementary/Secondary (0-12) College (1-4 or 5+) 1 2	Service Technician	Business Machines
land	be filec ental H rked ot	To Be	17. Father's Name (First, Middle, Last) Francis J. Kiernan	18. Mother's Nam	e (First, Middle, Maiden Surname) ${ m d}y$
Mary	I 2 should lith and M 27 is mai r traumat		19a. Informant's Name/Relationship (Type, Print) Mary Theresa Kiernan/Wife	9b. Mailing Address (Street and Number or Rura 2921 North Leisure Wo	al Route Number, City or Town, State, Zip Code) rld Blvd., #427, Silver Spring MD 20906
Baltimore, Maryland 21215-0036	age 1 and ent of Hea nt: If item ry or othe		1 Burial 2 X Cremation 3 Removal from State		Date 20c. Location - City or Town, State Alexandria, VA
Baltiı	permit. P Departm Importal any inju		21_Signature of Funeral Service Licensee	22 Name and Address of Facility Francis J. Collins	
			23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death) Atherosciere Due to (or as a consequence)	etic Cardiovascu	lar Disease
	Examiner	je l	Sequentially list conditions, b.		
	d d	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	an (192)	
	be executed sician and burial-test	dical Ex	resulting in death) Last Due to (or as a consequence	ce of):	
760	icate t phys	ledic	d		
Box 687	e death certificate be execute the attending physician and thed for use as the burial-to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
s, P.O.	ires that the dea signed by the a Id be detached f	by	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	The law requires that the sate has been signed by the page 2 should be detach	Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
tal	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec	sk only one)
f Vi	Physic this or	은	1 ☐ Inpatient 2 ☐ ER 27. Manner of Death 28a. Date of injury 28	Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
	Attending Physician: If death. Sector: After this certific by the funeral director,	icate	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury work? M 1 □ Yes 2 □ No	
Division	il or Atten after deat Director: d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check conly one) 3 Certifying Physician: To the best of my knowledge only one) 3 Certifying Nurse Practitioner: To the best of my knowledge only one) 1 Certifying Nurse Practitioner: To the best of my knowledge only one of the best of my knowledge on the best of my knowledge only one of the best of my knowledge one of the best of my knowledge on the best of my kn	nd/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s) and manner stated
		2	29b. Signature and title of cartifler	29c. License number	29d. Date signed (Month, Day, Year)
	10+1		30. Name and address of person who completed cause of death (Item 23	D0060319	
			DARCIE HAMMER. 18101	PRINCE PHILIP DR	2, OLNEY, MD 20832
	Sta Registr		31. Date filed (Month, Day, Year) OCT 31 2012 32. Registrar's Signature	park	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death November 5 2012 **Physician** Beverly Kay Lint 6:26 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Golden Living Center Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 1 M 2 K F 211-36-3503 64 Maryland Director 7/13/1948 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Experiment is ust be notified at Director 1 ☐ Yes 2 No Allegany Cumberland MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13301 Winchester Road Box A6 21502 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married δ 1 ☐ Yes 2 📉 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul W. Lint Rose (Corley) Lint 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13301 Winchester Rd Box A6 Paul Lint/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Scarpelli Funeral 11/6/2012 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home P.A 21. Signature of Funeral Service Lic 108 Virginia Ave Cumberland MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1000 33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TILL State

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Registrar DHMH 17 Rev 1/2001 pta.mD

Year

31. Date filed (Month, Day,

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692

32. Registrar's Signature

[Cont Pive Suite 101 Cumbelled, Mb 21503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1_ARSEN Physician/ KTOBER Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 507-50-2550 Months 1 🛚 M 2 🗆 F **Director** 12/16/1933 78 Minnesota permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be provided once. 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 🗆 Yes 2 🛣 No Maryland | Prince George's Suitland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20746 4706 Pickett Court Was Decedent Ever 1953-Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1953 1 X Yes 2 Nd 961 Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sjoboen Hazel Elmer Leander Larsen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4706 Pickett Court, Suitland, MD 20746 Ruth Darlene Larsen/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Waldorf, Maryland Trinity Mem'1 Cem. 11/2/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility George F. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 Part 1. Enter the disease, or complic shock, or heart failure. List only one s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complicat Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician SUSIS Medical resulting in death) Due to ras a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate betwithin 24 hours after death.

To the Funeral Director, After this certificate between properties or an experience of the former of the form IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pragtitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29h. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES-000 OCTOBER 30 2012 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 1800 ORLEANS ST BALTIMORE MD 21287 105 0

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year,

32. Redistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0200 Physician/ Patsy Carolyn Gilliam Long 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre de Grace Harford Memorial Hospital g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 215–32–8541 Funeral Jan. 6 Year)932 North Carolina 1 □ M 2 🗓 F 80 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State the Maryland Completed by Funeral Director notified 1 Yes 2 X No Aberdeen Harford 28a-f Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō ms 23a or must be r 21001 U.S.A. 3 Oakdale Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Reece Gilham Carrie Phipps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 648 Ragan Road, Conowingo, Maryland 21918 Michael Long (son) or other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Bel Air Memorial
Gardens 1 Burial 2 Cremation 3 Removal from State 11/05/12 Bel Air, Maryland injury of 4 ☐ Donation 5 ☐ Other (Specify) Signafure of Funeral Service Lio, nse Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMOCOCCAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death injury (Month, Day, work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of sertifier 11-1-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Havrede Grace, MD 21078 thawala 601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

AMENDED # 1, 11/08/12, RML, ST. MARY'S COUNTY
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle, LEBLANC 2. Date of Death Physician/ Month Louise---Harding---LeBlane :15 a November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Solomons Nursing Center Solomons Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11/29/1928 1 🗆 M 2 💢 F Months Hours Min Mary Land Director 215-56-9954 83 Usual Residence of Decedent 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? Funeral 23a 46135 River Hill Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. and 2 should be filed within 72 hours after or Health and Mental Hygiene.
tem 27 is marked other than "natural", or þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Frederick Leonard Harding, Sr. Lillie Mae Downs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and Department of Healt Important: If item 2 any injury or other t 46135 River Hill Road, Lexington Park, MD Lenore Blevins/Daughter 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Memorial Cem. 11/10/2012 Waldorf, Maryland Signature qui inner l'Serve Licensee Michele Brinsfield 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD M0165 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Atherosclerotic Physician/ (andio-Vasculandisease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Cardio vascular di rease lynentensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopathy Records, 1 Tes 2 No 3 Probably 4 🗷 Unknown fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Renal In subbsulency 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔁 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D. 50653 GYAN .C. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURANA 8 pml Deale church ton Road Deale 31. Date filed (Month, Day, Year) 32 Registrar's Signature NOV 0 7 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 2012 Physician/ November Alice Ditzel Littlepage 7:30 а м Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Howard Ellicott City Ivy Manor Chestnut Assisted Living 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) Director 220-18-9472 1 🗆 M 2 🔀 F 88 MD 02/06/1924 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No West Friendship MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21794 United States P.O. Box 350 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 XWidowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) B & O Railroad Logistics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Liebeck Arthur Ditzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 350 West Friendship, MD Ann Chaillou - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 11/06/2012 Baltimore, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Sign ur of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): 24 hours after death. From this certificate has been signed by the attending physician and Fruncial Director. After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death 1 Yes 2 g g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Living 1- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi 29b. Signature and title of certifier 2012 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Andrew Lazris, MD

NOV O

31. Date filed (Month Day, Year)

Barke

6334 Cedar Lane

21044

Columbia, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 26, 2012 Physician/ Helen Marie Liesmann 5:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Nursing Center, Inc. Adelphi If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 578-22-0214 Director 1 M 2 X F 88 April 17, 1924 WASHINGTON, DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2X No MD Carroll Taneytown 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 139 Saddletop Drive 21787 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Henry Jackson Marguerite Marie Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert C. Jackson/Brother 139 Saddletop Drive, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Nov. 1, 2012, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Si wure Funeral Servic Licensee Francis J. Collins Funeral Home Inc. Lates 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician Dementia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Failure to Thrive 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed To the Hospital or Attending Physiclan: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifig

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Njide Udochi,
31. Date filed (Month, Day, Year)

31

D51897

8900 Columbia Pkwy., Suite G, Columbia, MD 21045

October 29, 2012

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Medical Examin				do Ramir		ez	4h Cihi To	um or lo	cation of Deat			Ic. County of Death	
		4a. Facility Name (if no Southern Mary			mber)		Clintor		Cation of Dead			Prince George	e's
Funeral		5. Social Security Num	ber	6. Sex	7. Age (In yrs. la	ast birthday)	If Under	1 Year Days	If Under 24Hr Hours Mir			M/DD/YYYY) 9. Bird Foreig	thplace (State or "Guatemala untry)
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ath w	Funeral	1 Never Married	2 XMa	rried Armed F	orces?	If	Yes, specify	Cuban, N	lexican, Puert	Rican, etc.)		White, etc.	
, or		3 Widowed	4 Dive	1 Yes orced If Yes, Give Yes	2 X No	1 2	Yes 2] No 3	luatem specify:	aran		Specify: W	nite
urs af tural	출	15. Decedent's Educ	ation (Spec	or Dates: cify only highest gra	de completed)	16a. Decede	ent's Usual C	ccupation	(Give kind of O NOT use re	work done	16b	. Kind of Business/	Industry
72 ho	ete	Elementary/Second	ary (0-12)	College (*	1-4 or 5+)	auring	most of work	ing me. D	O NOT use te	ili od j			
036 rithin ane.	Completed	3				-	Mech	anic		e (First, Middle		Automot:	ive
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121 d be fi ental arked vent,	Be	Amilca 19a. Informant's Name	r Ra	mirez P	imente.	L N10h Maili	na Address						e, Zip Code)
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nd 2 saith e saith e 2 raum	ŀ	Kenneres 20a. Method of Dispos	K .	Martine	20b.	Place of Disp	osition (Nam	e of ceme	tery,	Date	200	c. Location - City or	Town, State
of Her t	-	1 X Burial 2		3 Removal fi	Om State	crematory or				101001			
Lim Pag ment tant; or of		4 Donation 5			- /	mily (Name and	ery	f Facility 1-7	W Pa	$\frac{2}{3}$	<u>Suatemal</u> n Funera	a Home
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	21. Signature of Fune		war	00								DC 20010
	-	Wanda C.	Bac disease, or	complications that of	6 I caused the death	n. Do not enter	the mode o	f dying, su	uch as cardiac	or respiratory a	rrest, s	shock, or heart	Approximate Interval
Physician /Medical	- 1	failure. List only	one cause	on each line.									Between Onset and Death
Examiner	- 1	Immediate Cause (Fir or condition resulting			a consequence of	of):							
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Box 68760, e death certificate be the attending physic ed for use as the bur	Ž	IF FEMALE: 23b. Was decedent pro	egnant in th		outcome of pred birth		Fetal death	3	Ectopic preg	nancy	ľ		Day Year
x 68 h certi rendin use a	Cia	past 12 months?			nant at time of d	ooth	Other (Spec	ify)					
BO e deat the at	Physician/M	1 Yes 2 No		known 9 Unkr			1 1 1 1 1		en in Dart I	23a Die	1 tobac	co use contribute to	o the cause of death?
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed refeath. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	by P	Part il. Other signific	ant condit	tions contributing	to death but not	resulting in the	e underlying	cause giv	ren in Part I.			No 3 Pro	
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Rec The la cate h	Completed										s 2	No 1 🗸 Y	res 2 No
of Vital Records, ng Physician: The law requir After this certificate has been si	Be	25. Was case referred examiner?	d to medica	Hospital:		e spio i i i		10.0	of Death (Checo		Dos	sidence 6 Oth	er:
hysic	70	1 🗸 Yes 2	No	'-	Inpatient 2	28b. Time		<u> </u>	at Work?	28d Descrit	e how	injury occurred	
ding F	ü	27. Manner of Death 1 Natural	5 Pen	ding FOUN	e of Injury th, Day,Year) D:	FOUND:	or unjuny		es 2 🗸 No	Passenge	er in a	uto-fixed object	ct collision
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	Certification	Suicide		id not be	/) Local Stre		201, 1001019			or Towr	State		
DIV To the Hospital or within 24 hours afte To the Funeral Dir		4 Homicide 29a. Certifier 1 C	ertifying P	hyeician: To the h	est of my knowle	dge, death oc	curred at the	time, dat	e and place, a	nd due to the c	ause(s)	and manner as sta	ated.
the I thin 24 the F	ledical	(Check only one) 2 V	ledicai Exa	aminer: On the basis	s of examination	and/or investi	gation, in my	opinion,	death occurre	d at the time, da	ate and	place, and due to	the cause(s)
2 2 2 2 2 2	Me	29b. Signature and ti	tle of certifi				290	. License				d. Date signed (M	
•		Cara	of 1	Hel Oa	w			O.C.N	1.E.		C	October 31, 20	12
		30. Name and addres	ss of person	n who completed ca	use of death (Ite	m 23a)							

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Carol H. Allan, MD

31. Date filed (Month, Day Year) NOV 02 2012

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

			For State	•	artment of Health and I	Mental Hygie	ene g. No. 2012	38020
			Registrar	Cer	tificate of Death		. No. 2 U 1 /2	
П	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Timothy	Leach		2. Date of Death Month	Day Year	3. Time of Death
M	Medic Examin		4a. Facility Name (if not institution, give street an		4b. City, Town, or Location of Death	October	30 2012 4c. County of Death	10:26 A ^M
	Examin	ier	13245 White Church Ci		Germantown		Montgome:	rv
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthr	place (State or Foreign
6	Director		465-82-4115 1XIM 2	□ F 65 Yrs.	Months Days Hours Min.	06/09/19	47 Miss	ouri
	d d	ايا	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ration			0d. Inside City Limits
	a-f sh iled a	t					- 1	1 Yes 2 X No
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	tems	Funeral Director		1 - 0	Vas Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	an Indian,
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15-	72 ho "na Tedic	nple	15. Decedent's Education (Specify only highest grade comp	oleted) (Give k	ent's Usual Occupation ind of work done during most of work ONOT use retired)	king 16	6b. Kind of Business/In Law	dustry
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p	iled wall Hyg othe	Be	17. Father's Name (First, Middle, Last)	<u> </u>	18. Mother's Nan	ne (First, Middle, Mai	iden Surname)	
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	Timothy Leach		Margare	t Elizabe	th Beal	
an.	shoul and I is ma	- 4	19a. Informant's Name/Relationship (Type, Print	19b. Mailin	g Address (Street and Number or Rui	ral Route Number, C	ity or Town, State, Zip (Code)
2	ind 2 lealth im 27 her tr		Kristina Dabrowski Le					
Baltimore,	ge 1 and the state of the state		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 🔀 Remova	20b. Place of Dispos cemetery, crem	istion (Name of latery or other place) tan ematory 20	mber 3	Oc. Location - City or To	
I‡i	it. Pa intmer intant injury		4 Donation 5 Other (Specify)			12 A	lexandria,	VA
Ba	Depa Impo any i		21. Signature of Funeral Service Leansee I RACO A. This		Name and Address of Facility Vol Funeral Home Gaithersburg	10 East	Deer Park	Drive,
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<u> </u>	iician: The certificate rector, pag		25. Was case referred to medical		26. Place of Death (Chec	1 Yes 2	No 1 L Yes	2 No
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on	Attending Physician: rr death. ector: After this certific by the funeral director,	fica	1. Natural 5 Pending 2 Accident Investigation	(Month, Day, roar)	M 1 Yes 2 No			
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	e Hospital 24 hours e Funeral I letely filled	Medical	Check 2 Medical Examiner: On t	he basis of examination and/or invest	occurred at the time, date and place, a igation, in my opinion, death occurred a death occurred at the time, date and p	at the time, date and	place, and due to the ca	use(s) and manner stated.
	To the Hospital or Attending Physician: Owithin 24 hours after death. To the Funeral Director. After this certific Completely filled in by the funeral director,	2	29b. Signature and title of certifier	A Deat of my knowledge,	29c. License number		d. Date signed (Month,	
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			30. Name and address of person who complete			utes so	154 An	0904
				NEK MO ON	OF Scluer S	Eulade	m0 2	2704
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Kelly Murray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min May 07, 1955 Maryland **Director** 220-58-1549 1 X M 2 T F 57 Usual Residence of Decedent show 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State with the Maryland Director 1 X Yes 2 No Maryland Allegany Frostburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 208 Centennial Street Completed by Funeral U.S.A 21532permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Propane Fuel Salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Anna Josephine Kelly John Charles Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Karen Sue Murray 208 Centennial Street Frostburg Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory Cumberland November 12, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cau nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Section tiable list over the en-Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2- No 1 Tes မ 1 Compatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending s after death. Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To tile best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 the only one) 29b. Signature and title of certilier 29d. Date signed (Month, Day, Year) 29c. License number 2012 O3021

State Registrar Robert

31. Date filed (Month, Day, Year)
NOV 0 9 20

Welik

Willowbrook

32. Registrar's Signature

Rd.

Cumberland

21502

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Moreland Physician/ Ronald William 2012 1545 P November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Examiner Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 04/28/1939 218-38-0624 Director 1 X M 2 □ F 73 filed within 72 hours after death with the Maryland at Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 ី No Arnold Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21012 392 Stanford Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 V Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Business Certified Public Accountant 27 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname)

Holt. Matlick Be 17. Father's Name (First, Middle, Last) should be file မ Moreland, Sr. Kirk James .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 392 Stanford Court, Arnold, MD 21012 Rebecca Enzor / Friend 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 11/10/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, F.A. 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EPSIS Physician/ Medical Due to (or as a consequence of): Examiner TAS TATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a nonsequence of Examir the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy
performed?

1 Yes 2 No 1 Yes 2 KNo 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 29d. Date signed (Mghth, Day, Year) an who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person ANNAROLIS 607 P 2000 PKW4 MEDICAL

State

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26 per PHY State of Maryland / Department of Health and Mental Hygiene AACO Health Dept. 11=2-12 KAH Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October Physician/ Albert James McKnight 2012 10:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 78 Farragut Road Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 039-18-3701 1 X M 2 D F 82 Yrs. 6/1/1930 Rhode Island Usual Residence of Decedent Pege 1 end 2 should be filed within 72 hours efter death with the Mayland ment of Heath end Mental Hygiene.

Sent: If Item 27 is marked other then "neturel", or Items 23e or 28e-f show ury or other treumetic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Directo 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 **USA** 78 Farragut Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Behavioral Psychologist Psvchologv 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Erna Conrad Girvan McKnight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl A. Lytle/Wife 78 Farragut Road, Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pege 1 e
Department of H
Importent: If Itel
eny Injury or oth 1 Durial 2 Removal from State Kalas Crematory 10/31/12 Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signatur Superal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Jomes Medical resulting in death) Examiner 0 Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami use as the burief-transit Cause (Disease or injury that initiated events Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the ettending physicien if funeral director, pege 2 should be deteched for use es the burie Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? OPD 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No TETInpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 8c. Injury at 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fur 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Robot el. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selonon: Isl R. 139 018 Robert M. Gogerfiel, ord 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

		1	For State Of IVId	aryiand / Dep Ce	rtificate of D			20 2	2 38024
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Rebeca Mercedes Mera		•		2. Date of Dear	th 200, 2012	3. Time of Death 6:30 P M
200	Medic Examin		4a. Facility Name (if not institution, give street and number)	· · · · · ·	4b. City, Town, or l			4c. County of De	eath
محمي			9042 Allington Manor Circle 5. Social Security Number 6. Sex 7. Age	West (In yrs. last birthday)	If Under 1 Year	erick If Under 24 Hrs.	8. Date of Birth	Freder	Birthplace (State or Foreign
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	tems tems	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of His If Yes, specify Cuban			14. Race - Ar	nerican Indian,
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 Never Married 2 X Married 1 1 Yes, Give Year or Dates.	NI-	1 ★ Yes 2 No			Specify: W	
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687		/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy				23d. Date of	delivery
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ecor	The law re ate has be page 2 sh	Completed						osy prior death	autopsy findings available to completion of cause of 1? Yes 2 \sum No
alB	nysician: The nis certificate I director, pag	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Chec	1 ☐ Yes k only one)	2 (2) (10)	ies 2 11 No
f Vit	Physic this ce	은	. □ IHOSDItal:	ent 2 ER/Outpatie		4 ☐ Nursing H		lence 6 Other (Sc	pecify)
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O	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical (29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e	xamination and/or inve	estigation, in my opinio	n, death occurred a	t the time, date a	nd place, and due to the	he cause(s) and manner stated.
	To the within 2 To the Somple	Ĭ	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	e best of my knowledg	e, death occurred at the 29c. License			he cause(s) and manne 29d. Date signed (Mo	
			* Lalkerol	MD.	D313	319		October 25	5, 2012
	\		30. Name and address of person who completed cause of clareto Albiol, M.D. 8218	leath (Item 23a) (Type, Wisconsir		e. 305.	Bethesda	a. MD 2081	4
	Sta		31. Date filed (Month, Day, Year) 32. Registr.	ar's Signature	barkel			<u> </u>	
	Registr	417	1101 116 (014 / 104)	un B. J	AR COLLEGE				

			State of Maryland / Dep		Mental Hygi	ene	38025
_			Togotiu.	ertificate of Death		g. No. 4 U 1 4	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) EMMA S •	MCCULLOCH	2. Date of Death NOVEMBER		3. Time of Death 4:15 A M
	Examin		4a. Facility Name (if not institution, give street and number) FOREST HILL HEALTH & REHAB CENTER	4b. City, Town, or Location of Deat FOREST HIL		4c. County of Deat	h RFORD
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Biri	thplace (State or Foreign
	Director		522-66-4641 1 □ M 2 □XF 99 Yrs.	Months Days Hours Min.	(Month, Day, Y		PA
	and show	ror	10a. State 10b. County 10c. City, Town or L	ocation	1		10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Cecil Colora				1 ☐ Yes 2 💢 No
	ith the 23a or st be n	ralD	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
	eath w	Funeral		21917 Was Decedent of Hispanic Origin? (S		USA 14. Race - Ame	rican Indian,
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married ☐ Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:	o Rican, etc.)	Black, White Specify:	e, etc. White
21215-0036	atural cal Ex	Completed by	3 XWidowed 4 Divorced Year or Dates.	edent's Usual Occupation		6b. Kind of Business/	
215	in 72 h e. nan "n Medi	lduc	(Specify only highest grade completed) (Give	e kind of work done during most of wor DO NOT use retired)	rking	bb. Killd of Busilless/	industry
	d with tygien ther th nt, the	Be Co	12 Hom	emaker		Own Hom	e
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To E	17. Father's Name (First, Middle, Last) William Hinnershitz	18. Mother's Na	me (First, Middle, Ma	iden Surname)	
ary	should be file and Mental I 7 is marked c raumatic eve			ling Address (Street and Number or Ru		ity or Town, State, Zip	Code)
	e 1 and 2 s t of Health If item 27 i			O Liberty Grove	e Rd. Co	lora, MD	21917
Baltimore,	0		Dana L A Gromation o E Homovar nom otato	ematory or other place) 11	/17/12	0c. Location - City or	
Ħ.	permit. Page Department Important: I any injury or once.		4 Donation 5 Other (Specify) Highvie 21. Shappy of Funeral Service Licensee	W Mem. Gardens		Fallston	, MD
m m	Dep any		Kichard L. Goodie	2. Name and Address of Facility R.T. Foard Fund 111 S. Queen St	eral Home Risin	e, P.A. g'Sun, M	D 21911
			23a. Part 1. Enter the disease, or compligations that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Ph. sician/ Medical	i	Immediate Cause (Final disease or condition resulting in death)	e			Onset and Death
-	Examiner		Due to (or as a consequence of):				
	+	iner	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying			V	
0	ecuted and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
0	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d				
68760	ificate g phy as the	Medi	IF FEMALE:				
9 X	ith cert	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of del Month	ivery Day Year
	ne dea y the a	Physician/Me	1	Other (specify)		Worth	Day Four
<u>Ч</u>	law requires that the nas been signed by the e 2 should be detach	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds,	equires een sig nould b	eted			1 🗆 Yes		robably 4 🖺 Unknown
<u> </u>	has by	Completed			24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
ř	an: The lifficate h		25. Was case referred to medical	26. Place of Death (Che	1 Yes 2	No 1 ☐ Yes	2 No
<u> </u>	hysicia nis cer I direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Othor	, , , ,	ce 6 🗌 Other (Speci	ify)
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	work?	28d. Describe how	injury occurred	
SIO	Attendar deat	Certificate:	2	M 1 Yes 2 No	28f. Location (Stree	et and Number or Rur	ral Route Number,
N	tal or irs afte al Dire		building, etc. (Specify)		City or Town, S	State)	
	Hospi 24 hou Funer stely fil	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred	at the time, date and I	place, and due to the c	ause(s) and manner stated.
	To the within to the comple	Σ	only one) 3 \square Certifying Nurse Practitioner: To the best of my knowledg 29b. Signature and title of certifier	e, death occurred at the time, date and p 29c. License number		cause(s) and manner as d. Date signed (Month	
			Devol 3Di	D32279	20	locumber 6	,2012
	0		30. Name and address of person who completed cause of death (Item 23a) (Type,		0101		
	Stat		DAVID DUNN - 615 W. MACPHAIL ROAD 31. Date filed (Month, All Mr) 7 7040 32. Registrar's Signature		21014		
	Registra	_	Ceneva B.	park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 13, Hursel Milbourne Sr. 10:15 a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehab + Nursing Center Salisbury, MD Wicomico 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 218-16-9479 Hours **Director** 1 X M 2 ∏ F 87 10/12/1924 MD Usual Residence of Deceden 2 should be filed within 72 hours after death with the Maryland that and Mental Hygiene.
27 Is marked other than "natural", or items 23a or 38a-f show traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Somerset Deal Island 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23279 Hursel Milbourne Road 21821 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 NoNavy Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates. 1944–46 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Somerset County (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) School System 12 School Bus Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Olbie Milbourne Mary Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once, Mary Milbourne / Wife 23279 Hursel Milbourne Rd. Deal Island, MD 21821 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Springhill Mem. Garden 09/19/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 917 W. Isabella St. Rennie Smith Funeral Home Salisbury, MD 21801 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Certificate: To 1 Tes Other: 2 🖳 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 32 Registrar's Signature

of person who completed cause of death (item 23a) (Type, Print)

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

29c. License numbe

ourtney L. Mayh		State of Maryland / Department For State Registrar Certificate			2012 eg. No.	3802
Physician	1/	Decedent's Name (First, Middle,Last)		2. Date of Deat	th	3. Time of Death
ledical Examin		Courtney Leigh Mayhew 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month November	r 9, 2012 4c. County of Death	1835 hrs
		2021 Huntwood Drive	Gambrills		Anne Arundel	
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) 2.12-21-1105 1 M 2 TF 27	If Under 1 Year If Under 24Hrs Months Days Hours Min		th(MM/DD/YYYY) 9. Birt 985 Foreig Cou	
any	Ī	Usual Residence of Decedent 10c. City, Town or Lo. 10a. State 10b. County 10c. City, Town or Lo.	cation			10d. Inside City Limits
*		MD Anne Arundel	Gambrills			1 Yes 2XX No
Aaryland 28a-f show	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cour	ntry?
th the Maryland 3a or 28a-f sho		2021 Huntwood Dr.	21054		USA	
items 2	Funeral	1 XXNever Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
ifter de		1 Yes 2XX No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2(X) No specify:		Specify:	White
hours a	ed by	during	dent's Usual Occupation (Give kind of most of working life. DO NOT use ret		16b. Kind of Business/II	ndustry
36 nin 72 l	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	nistration		Human Resou	irces
5-0036 led within 72 tygiene. other than	5	17. Father's Name (First, Middle, Last)	18.Mother's Name		Maiden Surname)	11000
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medica	å	John Mayhew		ia Kyle		
O g B in a l	2		ling Address (Street and Number or l $1\ ext{Huntwood}\ ext{DR.}$ G		nber, City or Town, State, S, MD 21054	, Zip Code)
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If iten 27 injury or other traum	ŀ	20a. Method of Disposition 20b. Place of Disp	position (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Her Important: If ite njury or other tr		4 Donation 5 Other Specify: Atlantic	Crematory 11/	14/2012	Glen Burni	ie, MD
Balt Sermit. Separtr Import		21. Signature of Fureral Service Licensee	Name and Address of Facility Ha	rdesty l	Funeral Home	e, P.A.
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not ente	2 Ridgely Ave. And rethe mode of dying, such as cardiac of			Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Mixed drug Intoxica Due to (or as a consequence of):	tion(Cocaine,Morp	hine)		Between Onset and Death
~- *		Sequentially list conditions, b				
		if any, leading to immediate Due to (or as a consequence of): cause. Enter Universiting Cause (Disease or injury that initiated				
scuted and transit	al Examiner	events resulting in death) Last Due to (or as a consequence of): d.				
0, be executed rsician and purial - transi	edical	▼ UNPENDED ☐ AMENDED 23a,27,28a-f	per me,g933 11-29	9-12 sm		
876 rtificate ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month D	yay Year
Box 6876(e death certificate the attending phytel for use as the b	Physician/M	Prognant at time of death	Other (Specify)		-	
P.O. s that the gned by t	2	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		obacco use contribute to	
ords, P.C. w requires that sheen signed to should be deta	e Led			24a. Was	an 24b. Were au	topsy findings available
Division of Vital Records, tal or Attending Physician: The law requints after death. al Director: After this certificate has been signed in by the funeral director, page 2 should the factor.	Completed			1 Yes	rmed? death?	ompletion of cause of
/ital	90	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpation	26.Place of Death (Check		Residence 6 🗸 Other	: Scene
of \ng Phy	- t	27. Manner of Death 28a. Date of Injury (Month Dev Yaer)		28d. Describe	how injury occurred	
sion trendi death. ctor: /	cation:	Natural 5 Pending fd 11-9-12 fd 18:		unknown	1	
Divis	Certific	3 Suicide 6 Could not be determined Single Fami.			Street and Number or Rui State) 2021 Hunt 11s,MD.	
	Medical	29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.				
	Ē∫	29b Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mor. November 10, 20	
By/	-	30. Name and address of person who completed cause of death (Item 23a)			1	
,			W. Baltimore Street, Baltimo	ore, MD 2122	23	
Sta Registra		31. Date filed (Month, Day, Year) NOV 1 3 2012 32. Resistrar's Signature	back			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ ™J10/26/5012 12:15P M Ella M. McCree Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Bradford Oaks Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours ᄱ 490-32-5102 Director 1 - M 2 X F 07/55/785P ZM Usual Residence of Decede 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location Director 1X Yes 2 No Temple Hills MD Prince George's 10g. Citizen of What Country? 10f. Zip Code by Funeral 20748 NZA 2723 Bellbrook Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 🗆 Yes 2 🔀 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Postal Service Administrative Clerk 75 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosie Jordan George McCree, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2811 Bellbrook St., Temple Hills, MD 20748 Joyce Ramey / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 11/02/2012 Clinton, MD 4 Donation 5 Other (Specify) 21. Signature of uneral Servi 22. Name and Address of Facility Strickland Funeral Services Enter the disease, or commercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused slock, or heart failure. List only one cause on each line. L Disce Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death 4 ☐ Pregnam = 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work?
1 \(\text{Yes} \) 2 \(\text{No} \) No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

1254

Medical

4 Homicide

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

29a. Certifier

determined

8

ann ks

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William 1. TANWEN WIN 11701 WUINGStun Rond Fort WASNINGTH MO

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Precitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 38029 12-07855 State of Maryland / Department of Health and Mental Hygiene Curtis Edward Murphy 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 16, 2012 1718 hrs Medical Examiner Curtis Edward Murphy 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Lanham Doctor's Community Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours Director Country) 577-76-2663 DC 1 X M 2 F 49 Yrs April 23 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. Count 1 X Yes 2 No l other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Hyattsville Maryland Prince George's Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 United States 1916 Virginia Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. African Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 1 Yes 2 X No specify: SpecifyAmerican 4 X Divorced 3 Widowed If Yes, Give Year 5 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) ltimore, MD 21215-0036
it. Pages 1 and 2 should be filed within 72 hox
rment of Health and Mental Byggene
ortant: If item 27 is marked other than "mai
y or other transmic event, the Medical Exp. Elementary/Secondary (0-12) College (1-4 or 5+) Private Information Technology 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maureen Jackson Eugene Murphy å 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Durrell Murphy - Son 1222 V Street SE Washington, DC 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Oct. 27, timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 2012 Ft. Lincoln Cemetery 4 Donation 5 Other Specify 22. Name and Address of Facility Stewart Funeral Home, Stanature of Funeral Service Licensee 20019 total 1-4001 Benning Road NE Washington, DC Runs M00560 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Medical Death a. Intracerbral Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED the attending physician ed for use as the burlal -UNPENDED Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown <u>6</u> diabetes mellitus, cardiomegaly Completed has been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' Yes 2 No 2 No 1 Yes page 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA After this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1__ Yes 2 __ No Pending the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined Homicide 29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending Physician: 24 hours after death. completely within 2

5_{JM}

29b. Signature and title of certifier

Pamela E. Southall, MD

31. Date filed (Month, Pay, Year)

MUY

amely)

outhall,

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

and manner stated.

Assistant Medical Examiner

32. Registrar's Signato

29d. Date signed (Month, Day, Year)

October 17, 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38030 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Emerson Jerome Moreland 2012 3:55 AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Hours Min. 275-24-9526 Director 1 🛛 M 2 🗆 F 81 Vrc October 24, 1931 Ironton, Ohio Usual Residence of Decedent show 10a. State 10d. Inside City Limits 10c. City. Town or Location with the Maryland at Director notified 28a-f 1 X Yes 2 □ No Maryland | Prince George's Hyattsville 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? ms 23a or must be r Funeral 20781 4114 Emerson Street USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian "natural", or iter dical Examiner rmed Forces?

☑ Yes 2 ☐ No USMC Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event, the Medical Examiu Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White res, Give Year or Dates. 1951–1956 Completed 3 N Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) Alcohol Enforcement Supervisor of Alcohol Enforcement Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard William Moreland Jesse Kizzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Moreland / Son 150 Puma Drive, Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If itel any injury or oth cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Marriottsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Gardens 11/6/2012 21. Signature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Facility

4739 Baltimore Avenue
Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC Immediate Cause (Final Physician/ FATAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CORON ARY Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): INTRAVISTRICULAR Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical HY AERTENSION Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ó Month Day Year Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by VASCULAR Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown FIBRILL ATION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed certificate 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 5 Pending 1 Natural Accident Investigation 24 hours after death Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the the only one within To the 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) ٥ NOV, 3, 2012 10+1 J:M

State

Registrar

CHEVERLY MS. 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-08229 Kenneth William					Ink. Ensure All Co of Health and Menta of Death	l Hygiene	ible. 2017	2 3803	
Physici Medical Exami	an/	Decedent's Name (First, Middle, Kenneth Willi	· · · · ·		·	2. Date of Death Month October 31,		3. Time of Death 0709 hrs	
		4a. Facility Name (if not institution, 3570 Williams Wharf R	give street and number) oad		4b. City, Town, or Location of I Saint Leonard	Death	4c. County of Death Calvert		
Funeral Director		knknown	5. Sex 7. Age (I	n yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours rs.	Min. 09/21/	(MM/DD/YYYY) 9. Bir Foreig 1962 M&	thplace (State or on providend	
ryland a-f show any <u>f once,</u>	al Director	Usual Residence of Decedent 10a. State 10b. County Maryland Calv 10e. Street and Number		c. City, Town or Loc St. Leona		1100	g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 X No	
death with the Maryland or items 23a or 28a-f show must be notified at once.		3570 Williams	Wharf Road	or in HS 142 V	20685 Nas Decedent of Hispanic Origin		United Sta		
after death w al", or items iner must be	by Funeral	1 X Never Married 2 Mar		No	f Yes, specify Cuban, Mexican, P Yes 2 X No specify:		White, etc.	ite	
136 hin 72 hours a e. than "natura edical Exami	Completed t	15. Decedent's Education (Specific Elementary/Secondary (0-12)	fy only highest grade comple College (1-4 or 5+)	during	ent's Usual Occupation (Give kin most of working life. DO NOT us equipment oper	e retired)	Contructio		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Con	17. Father's Name (First, Middle, L William James				Name (First, Middle, Ma Pauline	warren		
MD 21 d 2 should I th and Mer a 27 is man	٩	19a. Informant's Name/Relationshi William J. Mont			ing Address (Street and Number Williams Wharf	r or Rural Route Numb Road St.	er, City or Town, State Leonard MD	, Zip Code) 20685	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked ofter than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spe 21. Signature of Funeral Service L	Nov 3 20		Is. MD				
Physician		23a. Part I. Enter the disease, or co	00	4	. Name and Address of Facility F 405 Broomes Is.	Rd. Port	Republic,	A MD 20676 Approximate Interval	
Medical Examiner		failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	n each line.	l Cocaine	Intoxication			Between Onset and Death	
	Jē.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ						
cuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ						
an an	dical	X UNPENDED	d. AMENDED 23a, p	ot.II,27,2	28a-f,per me,g9	33 11-29-12	2 sm		
Box 68 e death certi the attending	Physician/Medical	FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1					23d. Date of delivery Month Day Year		
ords, P.O. w requires that the as been signed by should be detach	à	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive Cardiovascular Disease					23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown		
fital Records, P.O. ristin: The law requires that the inis certificate has been signed by director, page 2 should be detacl	Completed					24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of	
/ital /sician: nis certifi director,	Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ✓ Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Scene Other: Sc							

Division of Vir To the Hospital or Attending Physic within 24 hours after death. To the Puoeral Director: After this completely filled in by the funeral dir

State Registrar DHMH 17 Rev 1/2001

OCME 2006

Medical Certification: T

27. Manner of Death

5 Pending

6 Could not be

Investigation

determined

Hillan

Assistant Medical Examiner

OCME

32. Registrar's Signature

JULL

30. Name and address of person who completed cause of death (Item 23a)

1 Natural

2 X Accident

3 Suicide

29b. Signature and title of certifier

arol

Carol H. Allan, MD

31. Date filed (Month, Day, Year)

ORIGINAL

28a. Date of Injury (Month, Day, Year)

barker

28b. Time of Injury

29a. Certifier (Check only one)

29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one)

2 Medical Examiner: On the basis of examination and/or invastigation in my onicion death occurred at the cause (s) and manner as stated one)

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

fd 10-31-12 fd 06:39 am

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Single Family Home

28c. Injury at Work?

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

1 Yes 2 X No

28d. Describe how injury occurred

subject took drug

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3570 Williams Wharf Rd. Saint Leonard, MD.

November 1, 2012

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ddie 5:05 PM ctoher 2017 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Park Takoina lontgomer Adventist Washington Hospita If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Country) 579-50-2001 **Director** 81_{/rs.} 1 🗆 M 2 🔀 F May 3, 1931 South Carolina Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
Tant: If item 27 is marked other than "natural", or Items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director W ashington DC N/A 1 XYes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 20011 1312 Gallatin Street, NW United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married ۾ Baltimore, Maryland 21215-0036 Specify: African 1 Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates A merican 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) D.C. Public Schools Elementary/Secondary (0-12) College (1-4 or 5+) Teacher 5+Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Maggie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1312 Gallatin Street, NW, Washington DC 20011 Haywood Mims, Jr. / husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or oth Date txX Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 10/29/12 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. Suitland, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 ndre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician, neumonio Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): tending physician and ruse as the burial transit or Attending Physician: The law requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?

1 Yes 2 No Month within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the accompletely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No <u>မ</u> 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 D Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of gerti 29d. Date signed (Month, Day, Year) 006742 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue 110

State Registrar 31. Date filed (Month, Day, Year)
OCT 31 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-08085 State of Maryland / Department of Health and Mental Hygiene Degly Melendez 1- For State Certificate of Death Rea. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Year 0613 hrs October 25, 2012 **Medical Examiner** Degly Ubaldo Monroy Melendez 4b. City, Town, or Location of Death 4c, County of Death 4a. Facility Name (if not institution, give street and number) Howard Route 1 at Kit Kat Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) 5. Social Security Number 6 Sex **Funeral** Hours Min. Months Days Director Jan.1,1992 Guantemala none 1X M 2 F 20 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County III Hyattsville 1 Yes 2 X No MD Prince George' 28a-f show . Pages 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene.

That: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 20783 Guatemala 1354 Langley Way Apt.6 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 X Never Married 2 Married White Guatemalan 2 X No 1 Yes Yes, Give Year 1 X Yes 2 No specify 3 Widowed 4 Divorced ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Storage Mover Storage Co. MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Enma Del Rosario Melendez Vasquez <u>De Jesus Monroy Portela</u> 19a. Informant's Name/Relationship (Type, Print) father/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abel De Jesus Monroy Portela 1354 Langley Way Apt. 6 Hyattsville, Md2078 ∠ua. Method of Disposition 200. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Flores, El Peten, 11/7/2012 Naranjo Guatemala 4 Donation 5 Other Specify Balti permit. Departn 21. Signature Funeral Service Lice PHILIP D. RINALDI FUNERAL SERVICE, P.A. <u>9241 Columbia blvd.Silver Spring,Md20910</u> 23a. Part I. Enter ty disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): g physician a UNPENDED AMENDED Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth Fetal death 2 past 12 months? Pregnant at time of death signed by the attendi 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ā Division of Vital Records, P.O. ğ Yes 2 ✔ No 3 Probably 4 Unknown Completed his certificate has been a director, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA this 1 🗸 Yes 2 No 28a. Date of Injury Oct 25, 2012 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Driver auto-motor vehicle collision Certification 1 Natural 0610 hrs 1 Yes 2 V No Pending Director: 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) Route 1 at Kit Kat Road, Jessup, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the] one) Medic and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME October 26, 2012 o ld u andl 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Perioder: Certificate of Death Reg. No. 2 0 2 3 8 0 3 4													
Registrar 1. Decedent's Name (First, Middle, Last)						IIICate of Death Re			Reg. No Death	0/2 0 1 /2	3. Time of Death		
	Physicia		Month Day Y							y Year 2012	2:50 a ^M		
	Medic Examin	(edical							. County of Dea				
		Montgomery Hospice-Casey House				Rockville				Montgomery			
	Funeral		,	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under Hours		Birth Day, Year)		thplace (State or Foreign buntry)	
H	Director	ŀ	114-44-6943 Usual Residence of Decedent	1 X □ M 2 □ F	59	Yrs.			April	25,	1953 N	IY	
	show	ō	10a. State 10b. County		10c. Cit	y, Town or Loc	ation		·			10d. Inside City Limits	
	Maryl 28a-f ptified	Funeral Director	MD Mont	gomery		Takoma	Park					1 Yes 2 XNo	
	h the	a D	10e. Street and Number 212 Hodges Lane				10f. Zip Code 20912			1 -	itizen of What Co USA	ountry?	
	th wit ms 23 must	iner				e [13 M	13. Was Decedent of Hispanic Origin? (Specify				14. Race - Ame	erican Indian	
36 fter dea	fter dea ', or iter aminer	þ	11. Marital Status 1 ☐ Never Married 2 🖾 Marr	Armed Fo	orces? 2 Ano	lf lf		n, Mexicar	n, Puerto Rican, etc.)	.0	Black, Whit	te, etc.	
Š	ours a atural	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates.				16a. Decedent's Usual Occupation				Kind of Business/Industry		
יי ני	72 ho	힅	(Specify only highest grade completed) (Give life D				kind of work done during most of working O NOT use retired)			1 100.			
212	within glene. er tha		Elementary/Secondary (0-12)	5	1-4 Or 5+)	Syst	ems Anal	yst		F	ederal	Government	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at	-1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. of Health and Mental Hygiene. filem 27 is marked other than "natural", or items 23a or 28a-f show filer 27 is marked other than "natural", or items 23a or 28a-f show fother traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, L Thomas Francis		ſcCarthy			18. Mother's Name (First, Middle, Main Patricia Kennedy					
ar <u>Z</u>	nould ind Me s mar		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Street a	and Numbe	er or Rural Route Nur	nber, City o	or Town, State, Z	ip Code)	
Σ̈́	id 2 st salth a n 27 is ertra		Deborah G. McCa	arthy/Wif	e	212 H	lodges La	ne, T	Takoma Par	k, MD	20912		
ore	gelar or of He or oth		20a. Method of Disposition 1 Durial 2 Cremation		n State	cemetery, cren	sition (Name of natory or other place		Nov. 3,		Location - City o		
弄	permit. Page 1 & Department of H Important: If ite any injury or ot once.		4 ☐ Donation 5 ☐ Other (S 21. Sign re of Funeral Service L	i	met		an Crema		2012 tv	_	exandria	A, VA	
Ba	Dep Imp		21. Sign wire of uneral Service Lives 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901										
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between										
F	nysician		Immediate Cause (Final disease or condition Rectal Cancer										
	Medical Examiner		resulting in death) Due to (or as a consequence of):										
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	Due to (or as a consequence of):								
	A arist	Examiner	cause. (Disease or injury										
	an and	Ä	that initiated events resulting in death) Last Due to (or as a consequence of):										
09	Attending Physician: The law requires that the death certificate be executed sr death. sr death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	dical		d	I d								
387	requires that the death certifica been signed by the attending pl should be detached for use as t	by Physician/Me	IF FEMALE:	23c If yes ou	utcome of pregn	ancv					22d Date of d	olivon	
ox (ath ce attenc for us	cian	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pr 4 ☐ Pregnant at time of death 5 ☐ Other (spe						23d. Date of delivery Month Day Year		
W	he de y the	hysi	1 Yes 2 No 9 Unknown										
<u>0</u>	that t ned b e deta	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to										
ds,	quires en sig ould b	ted	1 \(\text{Yes} \) 2 \(\text{\text{\$\text{\$\Z\$}}} \) No										
Sor	aw rei ias be e 2 sh	Completed							a	Vas an utopsy erformed?	prior to	utopsy findings available completion of cause of	
Re	cate h	ខ្ល							1 🗆 ,	es 2 🔯		es 2 No	
ital	certifi	la B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	7	7 == 10:	Oth	or:	ath (Check only one)		Hospi	ce	
<u>></u>	Phys r this eral d	e: 12	27. Manner of Death	28a. Dat	Inpatient 2	28b. Time of	f 28c. Injui	y at	lursing Home 5 F		ury occurred	ecity)	
ou c	nding ath. r: Afte ie fun	icat	12☐ Natural 5☐ Pendii 2☐ AccidentInvesti	19	onth, Day, Year)	injury	injury work? M 1 ☐ Yes 2 ☐ No		□No				
Division of Vital Records, P.O. Box 687	or Atte after des Director in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be 28e Place of Injury - At home fan			street, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
٥	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has "completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check (e cause(s) and manner stated.		
	o the rithin 2 the l	ž	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and/title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	F 3 F 50		Dabrah Miller CRNP R143201 10.28.12										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 1355 Piccard Drive, Rockville, MD 20850													
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature Acceptance 1. Accepta													

Hector Lishel Rosales -12-08152 mayorga Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day October 27, 2012 0910 hrs **Medical Examiner** Hector Leonel Rosales Mayorga 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours c**Guna**temala Director none 34 Aug. 29, 1978 1 X M 2 F Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. MD Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1214 Stillmeadow Place 21703 Guatemala 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No Guatemalan White If Yes, Give Year 1X Yes 2 No specify: 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** Laborer Window Co. 10 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Hector Roberto Rosales Dora Maria Mayorga Mayorga 19a. Informant's Name/Relationship (Type, Print) (brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 2007 8 3 Byron Roberto Rosales Mayorga 8224 14th Avenue #301 Hyattsville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 11/9/2012 | 20c. Location - City or Town, State 11/9/2012 | Ipala, Chiquimula, crematory or other place)
Municipal Cemetery 1 🔀 Burial 2 Cremation 3 🔀 Removal from State Department of Important: I 4 Donation 5 Other 21, Simulature of Funeral Service Licen PHTL TPOOR SERVICE, P 9241 Columbia Blvd. Silver Spring, Md2091(er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Other Nursing Home 5 Residence 6 Other tor: After this of the funeral dire DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month Day Year) Oct 27, 2012 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject fell from ladder 1 Natural 0824 hrs Division 1 ✓ Yes 2 No within 24 hours after death.

To the Funeral Director:
Completely filled in by the f 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 628 Victorianna Drive , Capitol Heights, MD determined (Specify) Construction Site 4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 2012 Ok 1.h 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (NOVP=0/2") 201 37 Registrar's Signat Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND PI LINE A 280&F / PER ME G933 11/15/12 TRT

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $10^{
m Month}$ $20\overset{\text{Year}}{12}$ Physician/ p^{M} Anthony Joseph Mileo Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** ronce Birthplace (State or Foreign Country)
 DC If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** June 11 Months 1 🕱 M 2 🗆 F DC 74 Director 578-50-2891 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 X No MD Calvert Huntingtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States 20639 1453 Bidwell Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. þ 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Completed 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Prince Georges County Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Bernard Mileo Bessie Christine Beall permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic tonce. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1453 Bidwell Lane, Huntingtown, MD 20639 Anthony A. Mileo / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Lee Crematory 10/06/2012 Clinton, MD 4 Donation 5 Other (Specify) 21. Signature of In ral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Gory J. Goff 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MULTIPLE INJURIES any Vientine Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has autopsy performed 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) of Vital funeral director, examinor? Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After 1 Natural
2 Accident injury work? 5 Pending October 2 20/2 MOTOR VEHICLE ACCIDENT Investigation completed filled in by the 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ANNE Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 32. State Registrar

780.Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 1,2012 Physician/ 11:58 PM John Francis Neitzey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Director 216-22-2465 1 🛛 M 2 🗆 F January 18, 1923 Washington, DC 89 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked at ther than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2X No MD Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 USA 6100 Westchester Park Drive, #1211 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Secondary (0-12) College (1-4 or 5+) Property Management County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Neitzey Lillian Gertrude Ager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740 Page 1 and 2 sl 6100 Westchester Park Drive, #913 , College Park,MD J. Matthew Neitzey / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 11/7/2012 4 Donation 5 Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RHY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardia disease or condition resulting in death) Due to (br as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) မ

Physician/ Medical Examiner requires that the death certificate be Division of Vital Records, P.O. Box 68760

the attending physiclan hed for use as the buria signed by the a has the Hospital or Attending Physician; The I hin 24 hours after death. the Funeral Director: After this certificate h mpletely filled in by the funeral director, page

Other: 2 X No 1 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 2ga. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

mDD 72075

Esm

within 2.

State Registrar

Certificate:

Medical

31. Date filed (Month, Day,

(Check

only one) 29b. Signature and titl

> Satyam Vashi 32. Registrar's Signature

02872

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

uck Rd, Lanham m D 20706

29d. Date signed (Month, Day, Year,

2012

			1 - State Registrar	State of	Maryland /		artment rtificate			d Menta		ene2 ()	2	38038
			1. Decedent's Name (First, Middle, Las	(t)						2. Date	of Death	Day Y	'ear	3. Time of Death
	Physici		Harold Joe NICHO	LS							ember		2	1:25 a. M
dia	/Medio Examin		4a. Facility Name (If not institution, give		oer)		4b. City, To		cation of De			4c. County of Wash		ton
			Golden Living Cer				16 1 Indon 1		erstov f Under 24 F		- (Diat			
B	Funeral Director		5. Social Security Number 6. Security Number 493–44–1532	ex 7. £ M 2 □ F	Age (In yrs. last i	Yrs.	If Under 1 Months			in. (Mor	of Birth oth, Day, Y t.4,1	938		lace (State or Foreign htry) Souri
	pu k		Usuel Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						1	0d. Inside City Limits
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	286-1	ect	Maryland Washing 10e. Street and Number	30011		uger	10f. Zip 0	Code			100	. Citizen of Wh	at Cour	ntry?
	3a or	Funeral Director	16902 Revere Road	d				21740				USA		
	ms 2	nera	11. Marital Status	12. Was Decede	ent Ever in U.S.	13.	Was Decede	nt ol Hisp	anic Origin?	(Specify Yes	s or No-	14. Race -	Americ White.	
36	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or itams 23a or 28e-f ahow or other traumatic avent, the Medical Examiner must be notified at	by Fui	1 ☐ Never Married 2☐XMarried 3 ☐ Widowed 4 ☐ Divorced	1 Tx Yes 2 If Yes, Give Year or Dat	es: 1957–6.	3	1 Tes, specii		Specify:	Jento Mican, e	ito.)	Specify:	wh:	
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	filed withi Hygiene. other than	Con	12	0	c	onst	ructio					cable		
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic avent, I.e.M.	Be	17. Father's Name (First, Middle, Last) Joe A. Nichols					18		Name (First, Clara		iden Sumame) e		
Z	should nd Men marke umatic	၉	19a. Informant's Name/Relationship (Type, Print)	1	9b. Maili	ng Address (Street and	d Number or	Rural Route	Number, (City or Town, St	ate, Zir	Code)
≅	and 2 sealth ar n 27 is		Clearsey Nichols									Maryla		
ē	f Head from other		20a. Method ol Disposition		ceme	of Dispo	osition (Name	e of		Date	20	c. Location - C	ity or To	own, State
e E	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi		ara		wn Men		k 11	L/9/12		Hagerst	own	, Maryland
Baltimore,	permit. Pages 1 and. Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Service Lice	isee /		/	2. Name and		-			UNERAL		
	40200		23a. Part1. Enter the disease, or com	nications that cau	used the death D							town, M	<u></u>	Approximate
	Physician /Medical Examiner		shock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or	r as a consequence	ce of):	wit	,	,	omy				Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequenc									
P.O. Box 6	The law requires that the death certificate be executed at hes been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bir	ome of pregnancy th 2 Fetel dea nt at time of death wn	ath 3[⊒Ectopic pre ⊒ Other <i>(spe</i>					23d. Date Monti		ery Day Year
Q	s that ned b e deta	y P	Part II. Other significant conditions of	ontributing to dea	ath but not resulting	g in the u	underlying ca	use given	in Part I.	23	e. Did toba	cco use contrib	ute to t	he cause of death?
ğ	quire en sig	edt	Diabeter w	e Willi	1 /	26	men	tic		_	1 🗌 Yes	200 NO 3	B 🗌 Prot	bably 4 Unknown
eco	e lawre	Completed by								24	a. Was an autopsy performe	24b. We pri	ere auto ior to co ath?	opsy lindings available empletion of cause of
a	icete										Yes 2	No 1L		2□ No
V.	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Other	1	Death (Chec				
n of	ing Phys After this uneral di	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month	patient 2 ER/ Injury 28I , Day Year)	D. Time of Injury	of 28	c. Injury a Work?	at Nursir			ice 6 Other		ry)
Division of Vital Records,	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2.	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place o	of Injury - At home g, etc. (Specify)	, farm, si	M reet, factory,		s 2□No		cation (Stre		r or Rur	al Route Number,
٥	pitei c ours af erei D filled ii	i Ce	29a. Certifier 1 Certifying Ph	vsician: To the I	pest of my knowle	doe dea	th occurred a	at the time	date and n	ace and due	to the cau	use(s) and man	ner as	stated.
	the Hos in 24 hi the Fun pletely	Medical	(Check only 2 Medical Examone)	miner: On the bas	sis of examination	and/or i	nvestigation,	in my opir	nion, death o	occurred at th	e time, dat	te and place, ar	nd due t	to the cause(s)
	Tot Tot	Σ	29b. Signature and title of certifier	1 1			29c.	License r	number	0 -	29	d. Date signed	(Month,	1
	X5.4		Short Tal	imod	car)			CCC	63	433	5	11/0	+	12012
	2400		30. Name and address of person who	completed cause	of death (Item 23	Ba) (Type	, Print)	1	4		.5. /9	nta!	A A	10 21742
		oto.	31. Date filed (Month Ray, Year)	MADC 32 AA	gistrar's Signatur		V17/	h-271	1 /1	N 7/	ryer	MON	1 1	112 / 12
	Regist	ate rar	NOV US 2	UIZ A	MARIANTAN A									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 201 8:30 P Leon NEWHOUSE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Greater Washington Hebrew Home of 8. Date of Birth 1 Year If Under 9. Birthplace (State or Foreign 24 Hrs. **Funeral** (Month, Day, Months Hours Country 1 X M 2 - F 97 095-07-3463 Pennsvlvania Director 915 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10h County 10c. City, Town or Location 10a, State injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Potomac Marvland Montgomery 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code Funeral 20854 11900 Smoketree Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Executive Vice President 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Watch Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Morris Newhouse permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Deborah Cymrot, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11900 Smoketree Road, Potomac, MD Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 10/28/12 E. Farmingdale, NY Ararat Cemetery Mt. 4 Donation 5 Other (Specify) 21. Signature of Eurera Service Con 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 NW. Washington Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ month disease or condition Medical resulting in death) a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Other (specify) Pregnant at time of death To the Hospital or Attending Physician: The law requires that the der within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempleted filled in by the funeral director, page 2 should be detached for g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No 1 🗌 Yes Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 26, 2012 8:25pm M Garr Navarro Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House-Montgomery Hospice Derwood 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months **Director** 528-54-6815 1 X M 2 D F 65 1947 Utah Oct. 1, 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medicel Examiner must be notified at</u> Director 1 Yes 2 X No Olney Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 1 Winding Oak Court 20832 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dorothy Garr Augustine Navarro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i 1 Winding Oak Court, Olney, MD 20832 Jean Ketcham Navarro (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot Page 1 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/27/12 4 Donation 5 Other (Specify) |Alexandria, Virginia Name and Address of Facility DeVol Funeral Home East Deer Park Drive ithersburg, MD 20877 21. Signature of Eugeral Survice Live Mel Gaithersburg, 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he irt failure. List only one cause on leach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cholangiocarcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): rn. After this certificate has been signed by the attending physician and shreral director, page 2 should be detached for use as the burial transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy]Yes 2. ⊠N 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\overline{\mathbb{X}} \) Other (Specify) (è 1 Yes 2 🔯 No 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗓 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death. Funeral Director: Al filled in by the within 24 hou

To the Fune

completely fi

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

R143201

10.27.12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muncaster Mill Road, Derwood, MD 20855 <u>Deborah Mil</u>ler, CRNP 6001

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3804 State of Maryland / Department of Health and Mental Hygiene 2 🕦 📗 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 4:11 p M Salvador Navarrete Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton P.G. Southern Maryland Hospital Center 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-19-1882 Director 1 XXXM 2 □ F 51 Aug. 10, 1961 El Salvador or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland Director Silver Spring 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20904 USA 13304 Octagon Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1x Yes 2 □ No Specify: Salvadorean 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Cleaning Business Owner of Health and Mental Hygie of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Maria Paz Navarrete Jose Dimaz Ramirez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13304 Octagon Lane, SIlver Spring, MD 20904 19a. Informant's Name/Relationship (Type, Print) Gloria Elsi Navarrete/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1.
Department of I Important: If it any injury or o' once. v. 2, 2012 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. Silver Spring, MD 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Dates Tehard I Silver Spring, MD 20901 500 University Blvd. W., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1,0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of been signed by the attending physician and should be detached for use as the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 5 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 V 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗹 No ဂ္ 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wendell Pierson, MD 7503 Surratts Road, Clinton, MD 20735

State

31. Date filed (Month, Day, Year)

31

2012

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ November 201º2 8:05 \mathbf{P} M O'Connor Kevin Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown 11823 Pheasant Trail If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days (Month, Day, Year) Hours Director 204-34-5720 1 K M 2 F 60 May 3, 1952 Pennsylvania show 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Hagerstown MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21742 11823 Pheasant Trail Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 2 💢 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supplier Quality Engineer Manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Kathryn Crilley Albert Leo O'Connor, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11823 Pheasant Trail, Hagerstown, MD Pamela T. O'Connor/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 11/8/2012 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complicate ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physician/ IE PATIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** REJECTION IVER TRANSPLANT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Unknown 9 Unknown Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy After this certificate has performed 1 🗌 Yes 2 🗖 No Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 1 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and MHe o 06 20061411 11.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) //// D MEDICAL 4AGERS TOWN KRISHNAMOORTHY 31. Date filed (Month,

State Registrar aistrar's Signature

12-08083 Oscar Francisco

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 38043 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 25, 2012 0613 hrs **Medical Examiner** Oscar Francisco Osorio Osorio 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Route 1 at Kit Kat Road Jessur Howard 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Director none 31 Feb.5,1981 1 XM Guratemala 2 F Usual Residence of Decedent 10d. Inside City Limits Iny 10c City Town or Location Prince George' Hyattsville 1 Yes 2 XNo MD 23a or 28a-f show notified at once. IMOFE, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
out: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 8239 14th Avenue Apt.301 20783 Guatemala Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. l other than "natural", or items the Medical Examiner must be White, etc. Armed Forces? 1 XNever Married 2 Married 1X Yes 2 No specify: Specify: White 2 X No Yes If Yes, Give Year or Dates: 4 Divorced 至 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Storage Mover Storage Co. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Salvador Antonio Osorio Be Floresmila Del Carmen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 ဥ 19a. Informant's Name/Relationship (Type, Print) companion Maria Sanchez Martinez 8239 14th Avenue Apt.301 Hyattsville.Md 20c. Location - City or Town, State Los Simientos San Jose, La Ara, Chiqui 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, Cemeterio de la 1 Burial 2 Cremation 3 Removal from State 11/7/2012 Encarnacion 4 Donation 5 Other Spe mula Guatemala 22 Name and Address of Facility
PHILIP D.RINALDI FUNERAL SERVICE, P.A.
9241 Columbia Blvd.Silver Spring, Md2091
Approximate Interval 21. Signature of Funeral Se 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** only one cause on each line Between Onset and /Medical Death a. Head and Extremity Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit certificate be executed Physician/Medical signed by the attending physician be detached for use as the burial -UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. tal or Attending Physician: The law requires that th ģ 1 Yes 2 No 3. Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed death? Yes 2 ✔ No 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other4 Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 Yes 2 No Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Oct 25, 2012 Passenger auto-motor vehicle collision 1 Natural 0605 hrs within 24 hours after death

To the Funeral Director: A
completely filled in by the fu 5 Pending 1 Yes 2 V No 2 🗹 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Route 1 at Kit Kat Road, Jessup, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 26, 2012 O.C.M.E. a 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signat 2012

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

OCME

12-08084 Carlos Osorio

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar				Ce	rtifica	te of D	Death			7.0	Reg. No.	2011	2 3004
Phys		in/	Decedent's Name			-							2. Date of De Month		Year	3. Time of Death
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,			4a. Facility Name (if Route 1 at K		-	ind numb	oer)			City, Town, Jessup	or Loca	tion of Dea	m		. County of Death	1
Fune	rai	-	5. Social Security No		6. Sex	7.	Age (In yrs. I	last birtho		If Under 1 Y	ear If	Under 24H	rs. 8. Date of E		DD/YYYY) 9. Bir	thplace (State or
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15-0036 filled within 72 hours after death with the Maryland I Hygiene. I Appgine.	in i	b	15. Decedent's Edu		or Dates:		completed)	16a. De					work done		Cind of Business/I	ndustry
72 hor	E	etec	Elementary/Secor	ndary (0-12)	Colle	ege (1-4	or 5+)			of working I			etired)			
5-0036 Jed within 7 Hygiene.	the Medical Examin	Completed	2					S	tora	ge Mo	ovei	<u>-</u>		S	torage	Co.
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_ u e	traum	ŀ	20a. Method of Disp	osition			20b.	Place of	Disposition	n (Name of	cemeter	way v.	Apt 6	200.1	ocation - City or	le Md20783 Town State
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Baltimo permit. Page Department	70 01	-	4 Donation 5 21. Signature of Fun			/	Er	ncar	eric naci	LON ne-end-Addr	es of Fa	 ¥⊆₩₩х т г	OT DIENT	mu	I <u>Ia, Gua</u>	temala .
Per Per E			Mela	W/W	relt	L			924	1 Co.	lumi	oia I	31vd.S	ilve	r SERVI	CE,P.A. ng,Md2091
Physici			23a. Part I. Enter the			that caus	sed the death	. Do not								Approximate Interval Between Onset and
/Medi Examir			Immediate Cause (F	inal disease		and Ext	tremity Inj	uries								Death
			or condition resulting	g in death)	•	ras a co	nsequence o	of):								
		ē	Sequentially list con if any, leading to imr	mediate	b. Due to (o	ras a co	nsequence o	of):		-						
_		Examiner	cause. Enter Under (Disease or injury th	at initiated	C.		nsequence o	· 6).								
ap_	- transit		events resulting in d	leath) Last	d.	i as a co	insequence o)i).								
that the death certificate be executed to the the attending physician and	ial - tr	Medical	UNPENDED		AMENI	DED										
760, icate be	the burial -	Med	IF FEMALE:			yes, out	come of preg	nancy						23d	I. Date of delivery	,
687 certific	e as t		23b. Was decedent p past 12 months?	oregnant in the ?	1. :	Live birth	n t at time of de	2 [Fetal		3Ec	topic pregr	nancy		Month D	ay Year
Box e death c	for use as t	Physician	1 Yes 2 N	o 9 🔲 Unki		Unknown		eath 5	Other	(Specify)						
O. But the de	-5		Part II. Other signifi	icant condition	ons contribu	ting to de	eath but not r	esulting i	n the unde	erlying caus	e given i	n Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
83 5	should be deta	d b											1 Y	es 2 🗸	No 3 Prob	ably 4 Unknown
ords, Flaw requires	plnod	Completed											24a. Was			topsy findings available ompletion of cause of
tal Reco	7	틹		17									perf	ormed? 2 ✔ No	death?	_
A iii	rector, page	Be C	25. Was case referre	ed to medical						26.Pla		eath (Check				
	iğ.	0	examiner? 1 Yes 2	2 No	Hospital: 1	Inpa	atient 2	ER/Outp	oatient 3	_ DOA	Other	4 Nursi	ing Home 5	Resider	nce 6 🗸 Other	: Scene
of Ving Physical After this	funeral	٦	27. Manner of Death 1 Natural		00	Date of I	injury y Yaar)	28b. Tir 0605 l	me of Injur	_	njury at V		28d. Describe		ny occurred	collision
ivisior or Attend after death	th	ăţ	2 Accident	5 Pendi	tigation						Yes 2	_				
Division tal or Attendiins after death.	d in b	Certification:	3 Suicide		not be		f Injury - At he			actory, office	e building	g, etc.	or Town,	State)		ral Route Number, City
Div Hospital or 24 hours afte Funeral Di	ly fille		4 Homicide 29a. Certifier		100		Major Road			at the time	data an	d place on			oad, Jessup, M	
D To the Hospital within 24 hours To the Funeral	completely filled in by	Medical	(Uneck only		niner: On the b	asis of e	xamination a								d manner as state ce, and due to the	
		₹	29b. Signature and ti	itle of certifier		ner state	ed			29c. Lice	nse num	nber		29d. [Date signed (Mor	oth, Day, Year)
3			(1 H	De.	400	200	X //			0.0	C.M.E.			Octo	ober 26, 2012	2
		-	30. Name and addre	ss of person	who completed	d cause o	of death (Item	n 23a)								
			Carol H. Alla								reet, E	Baltimore	e, MD 21223	3		
		ate rar	31. Date filed (Month	, Day, Year)	012	2. Regis	strar's Signat	ure A	arken	1			_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMFND#15perINF,11/5/12;BW,McCo Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month October 2012 Year Physician/ 26, Florence O'Keefe 2:30 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ingleside at King Farm Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Days (Month, Day, Year) Director 032-20-5207 85 1 3 M 2 □ F June 29, 1927 MA Usual Residence of Dece item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5411 McGrath Blvd. Apt. 20852 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 1944-47 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) al Hygiene, I other than Technical Marketing Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F. is marked of permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or extend ည Leo Gray O'Keefe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy O'Keefe/Daughter McGrath Blvd. Apt. 1221 Rockville, MD 20852 Date 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2012 Silver Spring, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. Silver Spring 500 University Blvd. W. MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MOnths Immediate Cause (Final Physician/ Esophageal Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's Disease 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed' death? Yes 2 X N 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director. After this certific pompletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 A Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number

State Registrar 5934 W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

D0601

22315

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38046 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Day, 2012 Physician/ 10:00 A M Genevieve Lucile Poorbaugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany 11218 Poe Avenue, NW Corriganville If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 07/20/1922 217-18-4057 West Virginia Director 1 □ M 2 🗓 F 90 Yrs Usual Residence of Deced 23a or 28a-f show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Corriganville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21524 USA 11218 Poe Avenue, NW Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cardiac Lab. Tech. Hospital is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Earl Peaslee Velma Audra Goff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is or other tra William P. Poorbaugh / Son P.O. box 331, Corriganville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Restlawn Mem. Gardens 11/08/2012 4 ☐ Donation 5 ☐ Other (Specify) LaVale, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signature of Funeral Service 404 Decatur Street, Cumberland, MD 21502 Part | En er the | sease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. It tonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition METASTATIC LARGE CEZL FOUR MINTHS Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence or) burial-tran resulting in death) Last Due to (or as a consequence of): physician the burial Completed by Physician/Medical P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregna
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, cate has been sig 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☑ No Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ျှ 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 8 D33417 November 5, 2012 un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James R. Moen, M.D., 1068 National Highway, LaVale, MD

DHMH 17 Rev 06-2011

Registrar

State

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32. Registrar's Signature

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			For State		State of	Marylan		artment of H		Mental Hyg	jiene	210	00017
			Registrar		1		Cer	tificate of E	Death		Reg. No.	112	3804/
П	Physicia	ın/	1. Decedent's Name (Firs							2. Date of Dea Month	th Day	Year	3. Time of Death
31	Medic		Jacob Phi 4a. Facility Name (if not in	llip I	isarci	<u>k</u>		4h City Tayya an	Location of Death	10	-	2012	7:41 AM
	Examir	ier	Golden Li			'/		Cumber		ı		ity of Death	
	Funeral		5. Social Security Numbe			Age (In yrs. la	st birthday)	If Under 1 Year_	If Under 24 Hrs.	8. Date of Birth	1	egany 9. Birthp	place (State or Foreign
	Director		209-01-40] M 2 □ F	0.0	Yrs.	Months Days	Hours Min.	(Month, Day,		Coun	try)
	d tow	_	Usual Residence of Dec 10a. State 10b.	County	*	9.8	, Town or Lo	cation		1 4/30	/1914	I PA	0d. Inside City Limits
	arylan a-fsh fied a	Director										Ι'	1 Yes 2 No
	or 28		10e. Street and Number	llegar	ı y	Cum	berla	10f. Zip Code			10g, Citizen o	f What Cour	
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	tems er mu	F.	11. Marital Status	aven R	12. Was Deceder			Vas Decedent of Hi	ispanic Origin? (Sp			ace - Americ	
36	ifter d ", or i amin	by	1 Never Married 2		Armed Force 1 Xes 2 If Yes, Give			f Yes, specify Cuba ☐ Yes 2 🛂 No		o nicari, etc.)		ack, White,	etc.
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	3 Widowed 4 I		Year or Dates	WWI	L				Speci	whi	
15-	72 hc n "na Aedio	nple.	(Specify o	Decedent's Ed nly highest grad	de completed)		(Give F	lent's Usual Occupa kind of work done of O NOT use retired)	ation during most of wor	king	16b. Kind of	Business/Inc	dustry
212	vithin giene.		Elementary/Secondary	/ (0-12)	College (1-4 o	or 5+)		tyContro	olInspe	ctor	Allec	ranvB	alliation
	filed val Hyg	Be	17. Father's Name (First, i	Middle, Last)			~			ne (First, Middle, M			Stice
ylar	should be filed within and Mental Hygiene. is marked other tha aumatic event, the I	은	John Pis	sarcik					Sophia	Bielik			
Maryland	2 should be th and Ment 27 is marked traumatice		19a. Informant's Name/R	elationship (Typ	oe, Print)		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number,	City or Town	, State, Zip C	Code)
	1 and 2 soft Health item 27 other tra		Edna Pis	arcik	/wife			9 DeHave	en Rd.	Cumberl			
lor		i	20a. Method of Disposition	emation 3			ace of Dispo emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location	n - City or To	wn, State
Baltimore,	pernit. Page 1 Department of Important: If it any injury or conce.		4 Donation 5 D		-	MD		VA Cemet			Flint		
Ba	permit. Departr Importa any inju		21. Signature of Funeral S	Service Liberise	<u></u>	3h	1	. Name and Addres	5	carpell			
	11000		23a, Part 1. Enter the dis	sease, or comp	ications that caus	sed the death	. Do not ente	08 Virgor Fr the mode of dying	ınıa AV. g, such as cardiac	or respiratory arre	eriano est,	L-MDZ	Approximate
25~	Physician/		shock, or heart failu Immediate Cause (Final	re. List only on	e cause on each	line. Vo na	٨.	1 02					Interval Between Onset and Death
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Sales Control	Examiner	l, l	Sequentially list conditio										•
	n #	ine	if any, leading to immedi- cause. Enter Underlying	ate	Due to (or a	as a consequ	ence of):						
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	oe exe	70	resulting in death) Last	L	Duc 10 (01 1	as a consequ	ence oi).						
Box 68760	death certificate be he attending physic ed for use as the b	Physician/Medic		_	d								
68	certifi nding use a	N/N	IF FEMALE: 23b. Was decedent pregr	nant 2	3c. If yes, outcor			1			23d. [Date of delive	ery
30X	death e atte	icia	in the past 12 month 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	is?	4 Pregnar	t at time of d	eath 3 L	Ectopic pregnanc Other (specify)	ey .		1		Day Year
P.O. E	hat the death ed by the atte detached for	hys	g 🗌 Unknown		g 📙 Unknow								
<u>o.</u>	v requires that been signed be should be det	by	Part II. Other significant	conditions co	ntributing to deat	h but not resu	ilting in the u	nderlying cause giv	en in Part I.				e cause of death?
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000	has b	Completed by								24a. Was a autops perfor	sy	o. Were autor prior to cor death?	osy findings available impletion of cause of
Ä	iician: The la certificate ha rector, page		25. Was case referred to i	dia-al						1 Yes		1 Yes	2 □ No
/ita	Physician: T this certifica eral director, p	m	examiner?	<u> </u>	lospital:			Othe	ace of Death (Checer:				
of Vital Records,	Attending Physician: The law requires that the radeath ar death are death estor. After this certificate has been signed by the funeral director, page 2 should be detach	e: To	27. Manner of Death		28a. Date of i	atient 2 🗌 I	28b. Time of	28c. Injury	4 ☑ Nursing H / at	ome 5 Reside			
no	ath. r: Afte	icat	2 Accident	Pending Investigation	(Month, I	Day, Year)	injury	M 1 🗆	? Yes 2□No				
Division	r Atte er de recto	Certificate:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of	Injury - At hor etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (St City or Town		ber or Rural	Route Number,
Ö	Hospital or 24 hours afte Funeral Dire stely filled in												
	Hosp 24 hor Fune stely fi	Medical	(Check 2 D M	edical Examin	er: On the basis of	of examination	and/or invest	occurred at the time igation, in my opinio	n, death occurred a	at the time, date an	d place, and o	due to the cau	use(s) and manner stated.
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer		only one) 3 LJ C 29b. Signature and title		Practitioner: To	the pest of m	y knowledge,	death occurred at the 29c. License		2	9d Date sign	ed (Month I	Day Year)
	6		•	Nh.	home				0 33280		NOV	1, 2	0/2
	San		30. Name and address of	person who co	mpleted cause o	f death (Item	23a) (Type, P	rint)	A				
	MRS		Sunil	Guy		×		Cent Au	4. Cin	buland,	MID	212	009
	Stat Registra	te ar	31. Date filed (Month, Day	2 2012	82. Regis	strar's Signati	ire Jaar	Led .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle Last Day 20 Month Physician/ 6:40PM 30mer · 0 -Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Heritage Harbour Health Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours. (Month, Day, Year) Country) 120-18-1187 Director 88 1 🗆 M 2 🗶 F New Jersey 1 end 2 should be filed within 72 hours efter death with the Maryland of Heelth end Mentel Hyglene.
Them 27 is marked other then "netural", or items 23e or 28e-f show offer treumetic event, the Medical Exprimer must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. Count Director 1 ☐ Yes 2 X No Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA Funeral 934 Beacon Way 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Mantal Status Black White etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry st grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Montgomery County Librarian 4 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Virginia Hoit John C. Davidson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9600 John Randolph Ct., Ellicott City, MD 21042 Todd W. Palmer / Son Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Depertment of h Importent: If Ite eny injury or ot once. 1 Burial 2 X Cremation 3 Removal from State 11-1-2012 Edgewater, MD Kalas Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Finanti Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PER ENSION Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exam certificate has been signed by the attending physician end irector, page 2 should be deteched for use as the buriel-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospitel or Attending Physicien: The law requires that the deeth certificate be to within 24 hours efter deeth.

To the Funerel Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be deteched for use as the bur Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 27. Manner → Death 28d. Describe how injury occurred Certificate: 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHBOOR SYEI 31. Date filed (Month, Day, Year)

NOV 02 2012

21061

29d. Date signed (Month, Day, Year)

Medical

29a. Certifier

29b. Signature and title of certifier

racks

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Rena L. Payne September 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Pocomoke 2574 Worcester Highway 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 216-54-9081 1 M 2 F 62 Yrs 09/18/1950 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f sho the M-dica Examiner must be notified at 10a. State Director 1 ☐ Yes 2 1 No Worcester Pocomoke 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21851 USA 2574 Worcester Highway Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 72 hours after Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates and Mental Hygiene. 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Consultant Hercules Co Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Juanita A. Harmon pe Upshur Harmon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 i 2574 Worcester Highway, Pocomoke, MD 21851 Lovetta A. Winn / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 2 Burial 2 Cremation 3 Removal from State Pocomoke, MD 4 Donation 5 Dother (Specify) 9/22/2012 Shiloh UM Cemetary 22. Name and Address of Facility Plane Smith Funeral Home Salisbury, MD 2180 Signature of Funeral Service License Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐XNo 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) Hospital: 1 Tes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number

State Registrar 31. Date filed (Month, Day, Year) NOV 13 2012 32 Registrar's Signatur

WARD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1200

DO058410

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PinKett b-ere A. 0643 10 13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shock Tarma lever Baltimore If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Days 7-30-9058 Min. **Director** 1 M M 2 D F Mary. items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at **Funeral Director** 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 2161 US 100 eachb 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" 3 Divorced 4 Divorced Iack Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ inkett ayse Theadore permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is m
any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Octeachblossom 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🗹 Burial 2 🗌 Cremation 3 🗆 Removal from State 12012 L'rossing levieter 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Adress of Famility
Henry Funeral Home, Signature of Funeral Service Licensee ae, MD. 21613 washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Intracranial Hunorrhage disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hemorrhage Sequentially list conditions, Examiner Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 🗌 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 72130

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

TL

5 cours St. Baltimore.

person who completed cause of death (Item 23a) (Type, Print)

Hazel Elizabeth	Puffenburger
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State of Maryland / Department of Health and Mental Hygiene

	Registrar Certificate of Death							Reg. No. 2012 3303				
Physicia Medical Exami		1. Decedent's Name (First, Middl HAZEL ELIZ/	ABETH PUFF						Day Yea 23, 2012	0/10 nrs		
		4a. Facility Name (if not institution 333 Mill Street	n, give street and num	iber)	4	b. City, Town, or Hagerstown		th	4c. County o			
Funeral Director		5. Social Security Number 236-22-5351	6. Sex 7	'. Age (In yrs. la 88		If Under 1 Year Months Day		rs. 8. Date of E in. 7/11/		9. Birthplace (State or Foreign Country) WV		
		Usual Residence of Decedent	1 M Z(L)F		Yrs.			//11/	1324			
and show any oce.	L	10a. State 10b. County WV BEF	RKELEY	10c. City,	Town or Location	nSBURG				1 10d. Inside City Limits 1 Yes 2 No		
eath with the Maryland items 23a or 28a-f sho ast be notified at occ.	Director	10e. Street and Number				10f. Zip Code	4.0.1		10g. Citizen of Wh	•		
with the	ral D	357 BOYD AVE	12. Was Dece	dent Ever in U.		Decedent of His			o- 14. Race	USA - American Indian, Black,		
er de	by Funeral	3 Widowed 4 Div	arried Armed For 1 Yes orced If Yes, Give Year or Dates:	2 No	1	es, specify Cubar	specify:	·	White Specify:	o, etc. WHITE		
72 hours "natur	eted t	 Decedent's Education (Specific Elementary/Secondary (0-12) 	cify only highest grade College (1-			's Usual Occupa est of working life			16b. Kind of Bu	siness/Industry		
5-0036 led within 72 hours aft. Hygicne. tother than "natural" the Medical Examine	Completed	9 17. Father's Name (First, Middle,	Last)		НОМ	IEMAKER	18 Mother's Non	o /Firet Middle	OW Maiden Surname)	N HOME		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than r event, the Medica	Be	CHARLES WILL	AM MASON		_		CLARA	ANNA M	IASON			
○ 용 급 : 호 : 혈	٩	OTHAL PUFFENBURGER/SON 357 BOYD AVE., MARTINSBURG, WV 25401								ı, State, Zip Code)		
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	20a. Method of Disposition 1							Date . 27,		City or Town, State		
Baltimore, permit. Pages 1 a Department of He Important: If its njury or other it		21. Signature of Funeral Service	ecify: Licensee	OLIV		2012 FIEDGESVILLE, WV 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402						
ញ ឧក្សន Physician		Robust C. G. 23a. Part I. Enter the disease, or	art Approximate Interval									
/Medical		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	Between Onset and Death									
		Sequentially list conditions,	Due to (or as a c									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c									
cuted ind transit	Exa	events resulting in death) Last	Due to (or as a c	onsequence of):							
8760, uificate be executed ng physician and as the burial - transit	n/Medical	UNPENDED	AMENDED						las a			
	ian/M	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?	e 1 Live bin	itcome of pregn h nt at time of dea	2 Feta		Ectopic pregr	nancy	23d. Date of o	Day Year		
O. Box 68 In the death certi by the attending according	Physicia		nown 9 Unknow	'n	□ Oth	er (Specify)						
P. es that igned be def		Part II. Other significant conditi	ons contributing to d	leath but not re	sulting in the ur	nderlying cause g	jiven in Part I.			oute to the cause of death? Probably 4 Unknown		
requisite properties of the pr	Completed by							24a. Was	psy pi	Vere autopsy findings available rior to completion of cause of		
tal Reco										eath? Yes 2 No		
Vital bysiciae this cert	o Be	examiner? Hospital:							Residence 6	Other: Scene		
C # _ ^ #	ion: T	27. Manner of Death 1 Natural 5 Pend	28a. Date of (Month, D	Injury Pay,Year)	28b. Time of In		y at Work? Yes 2 No	28d. Describe	how injury occurre	d		
Division pital or Attendio ours after death, oeral Director;	Certification:	3 Suicide 6 Could	tigation 28e. Place mined (Specify)	of Injury - At ho	me, farm, street	, factory, office b	uilding, etc.	28f. Location or Town,		r or Rural Route Number, City		
Division To the Hospital or Attenwihin 24 hours after death To the Fuorral Director:	Medical Ce	29a. Certifier (Check only 1 Certifying Ph	ysician: To the best on the basis of	examination an								
To viit	Me	29b. Signature and title of certifie	and manner sta	ted.	1	29c. License			29d. Date signe	d (Month, Day, Year)		
<u>, </u>	-	30. Name and address of person	who completed cause	of death (Item	23a)	O.C.I	VI.E.		October 24,	2012		
3√		Zabiullah Ali, M.D.	Assistant Medica	Examiner	900 W. Ba	altimore Stre	et, Baltimore	, MD 21223				
Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 6	2012 32. Regi	strar's Signatur	. par	las						

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3 Time of Death Month Day November 2, 2012 Medical Examiner 2058 hrs Rust, III Samuel Cornelius 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A **Baltimore** University Medical Center Birthplace (State or Foreign Texas
Country) 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Min Director 229-04-8937 01/01/1962 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits iny 10a. State 10b. County Bedford Bedford Yes 2 No PΑ iral", or items 23a or 28a-f show niner must be notified at once. ies I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3618 Evitts Creek Road 15522 IISA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Drywall Finisher Construction MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Cornelius Rust, II Norma Lee Cruikshank Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1089 Centerville Road, Bedford, PA Samuel C. Rust, II / Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c, Location - City or Town, State Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Pages 1 Fellowship Cemetery 11/07/2012 Centerville, PA Donation 5 Other Specify. 22. Name and Address of Facility Adams Family Funeral Home, P.A. gnature of Funeral Seprice Licensee 404 Decatur Street, Cumberland, MD 21502 rt,l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Fetal death Day Live birth 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown After this certificate has been signed by the funeral director, page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Othera Nursing Home 5 Residence 6 Other DOA 1 V Yes No 28a. Date of Injury 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27 Manner of Death Certification Subject passenger of motor vehicle involved in Nov 2, 2012 Natural 1756 hrs 1 Yes 2 ✔ No death. Director: 5 Pending motor vehicle accident 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) I-695 at Route 40, Baltimore, MD determined the Funeral (Specify) Interstate/Express 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 3, 2012 who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signature State arke 5 20 Registra

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State of Maryland / Department of Health and Mental Hygiene

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n and Mental Hygiene	2	U	lectoral district	2	3	Ö	U	J	Ü	

Patrick Wayne Reis	inger State o 1- For State	f Maryland / De	epartment of Certificate of		d Mental H	ygiene	20	12 3803.		
Dhysisian/	Registrar 1. Decedent's Name (First, Middle, Last)		Jeruncate of	Death		R 2. Date of Dea	eg. No.	3. Time of Death		
Physician/ Medical Examiner	Patrick Wayne	Reisinger				Month Novembe	Day Year	1459 hrs		
	4a. Facility Name (if not institution, give s			4b, City, Town, or L	ocation of Death		4c. County of [Death		
	45474 Medleys Neck Road			Leonardtown	1		St. Mary's			
Funeral	Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year				9. Birthplace (State or oreign		
Director	219-15-7351 1x A	1 2 F	30 Yrs	Months Days	Hours Min	08/25/	30 4 4			
A	Usual Residence of Decedent 10a. State 10b. County	Iao a	City, Town or Locat					10d. Inside City Limits		
ow any			only, Town or Local			• • • •	1 Yes 2 🗷 No			
yiand	Maryland St. Ma:	ry's		Me 10f. Zip Code	chanicsv	10g. Citizen of What Country?				
the Maryland a or 28a-f sh lifted at onc		T			659		og. Oktzor of Tithak	USA		
s 23a notifi notifi	26280 Abigai1 11. Marital Status	Lane 12. Was Decedent Ever i	n U.S. 13. Wa	s Decedent of Hisp		pecify Yes or No	- 14. Race - A	American Indian, Black,		
death with r items 23 nust be no 'uneral	1 Never Married 2 Married	Armed Forces?	If Y	es, specify Cuban,			White, e			
s after d	3 Widowed 4 Divorced If		1 🗌	Yes 2 X No	specify:		Specify:	White		
natura xamii	15. Decedent's Education (Specify only	highest grade completed	d) 16a. Deceden	t's Usual Occupation			16b. Kind of Busin	ness/Industry		
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212 Ment Ment mark	19a. Informant's Name/Relationship (Typ		19b. Mailing	Address (Street			nber, City or Town,			
MD d 2 sho Ith and n 27 is numati	Glenn Paul Reising					echanic	sville, M			
	20a. Method of Disposition 1 X Burial 2 Cremation 3		Ob. Place of Dispos crematory or oth		netery,	Date	20c. Location - Ci	ity or Town, State		
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other trees.	4 Donation 5 Other Specify:		St. Franc	is Xavie	r 11/	8/2012	Compto	on. MD		
Salti rmit. epartn nport	21. Signature of Funeral Service License	ê , , .	22. N	ame and Address	of Facility Pley-Gar	diner F	uneral Ho	ome. P.A.		
and the second	Muchael & S	aroliner	41	Jyu renw.	ick arre	et Leon	lardtown,_	MU ZUOSU		
Physician /Medical	failure. List only one cause on each line.									
xaminer		traoral Gunshot W						Death		
And the state of t		le to (or as a consequent	de or).							
Je Je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
ted nsit Examiner	Disease or injury that initiated	e to (or as a consequent	ce of):							
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ox 68760, eath certificate be executed attending physician and for use as the burial - transit sician/Medical Ex	UNPENDED	AMENDED								
68760 ertificate b ding physi e as the bu	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p			¬		23d. Date of de			
certification certification cian	past 12 months?	1 Live birth 4 Pregnant at time of	5 da -40-	tal death 3 L her (Specify)	Ectopic pregna	ancy	Month	Day Year		
Box 6876 e death certificate the attending phy ed for use as the b hysician/M	1 Yes 2 No 9 Unknown	9 Unknown	3 🗀 Ot	ner (Specify)						
P,O, E es that the d igned by the detached iby Phy	Part II. Other significant conditions	ontributing to death but n	ot resulting in the u	inderlying cause gi	ven in Part I.			te to the cause of death?		
cords, P.O. law requires that the has been signed by 2.2 should be detach npleted by P.								Probably 4 Unknown		
Records, The law requires ficate has been sig, page 2 should be						24a. Was autop	osy prio	re autopsy findings available or to completion of cause of		
Recorder the land and a sage 2						perfo 1 ✓ Yes		ıth? ✓ Yes 2 No		
tal Rection: The certificate ector, page	25. Was case referred to medical examiner?				of Death (Check					
Physic Physic all direction To F	1 ✓ Yes 2 No	spital: 1 Inpatient 2					Residence 6	Other: Scene		
n of ding Pl After funeral	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury FOUND:	28b. Time of I		yat Work? es 2 ✔ No	Subject sho	how injury occurred of self			
Sio Atten r deatl ector: by the	2 Accident Investigation	Nov 1, 2012 28e. Place of Injury - A	1444 hrs			28f Location (Street and Number	or Rural Route Number, City		
Division of Vital Records, pital or Attending Physician: The law require ours after death. The all Director. After this certificate has been similed in by the funeral director, page 2 should be tilled in by the funeral director, page 2 should be tilled in by the funeral director, page 2 should be tilled in by the funeral director, page 2 should be tilled in by the funeral director, page 2 should be tilled in by the funeral director.	3 ✓ Suicide 6 Could not be determined	(Specify) Single F		x, ractory, cines bu		or Town. S				
Hospi 24 hour Funer ely fill	29a, Certifier 1 Certifying Physician	: To the best of my know	vledge, death occur	red at the time, dat	te and place, and	due to the caus	se(s) and manner as	s stated.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	one) 2 Medical Examiner: C	n the basis of examination	on and/or investigat	ion, in my opinion,	death occurred a	at the time, date	and place, and due	to the cause(s)		
F 3 F 8 B	29b. Signature and title of certifier	MI	`	29c. License number			29d. Date signed	(Month, Day, Year)		
	Alla bia	and Wills	5	O.C.N	ı.E.		November 2,	2012		
	30. Name and address of person who con			. D - II' -	5	140 046	22			
5) RME		istant Medical Exa		. Baltimore St	reet, Baltimo	ore, MD 2122	<u> </u>			
State Registrar	31. Date filed (Month, Day, Year) NOV 0 7 2012	32/Registrar's Sig	A. per	w						

OCME

			Please	Type or Print in E State of Maryland				-	_).
		•	For State Registrar	State of Maryland		tificate of L			Reg. No. 2012	38054
	Physicia		1. Decedent's Name (First, Middle, Last) Mildred M. Ruppel)				2. Date of Dea	th : 28, 2012	3. Time of Death 7:40A. M
	Medic Examin	er	4a. Facility Name (if not institution, give s Renaissance Cardens at		e	4b. City, Town, or Silver S	Location of Death		4c. County of Dec	orge's
	Funeral Director		5. Social Security Number 307–20–8589 6. Set 1 [3 , , , ,	st birthday) 38 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day March2	7,1924 Inc	irthplace (State or Foreign ountry) liana
	Aaryland 8a-f show tified at	Director	10a. State 10b. County Maryland Prince G		Town or Loc					10d. Inside City Limits
	with the N s 23a or 2 lust be no	I = I	10e. Street and Number 3160 Gracefield Ro	ad, 0G3335		10f. Zip Code 20904			10g. Citizen of What C United St	•
980	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Vas Decedent of Hi i Yes, specify Cuba ☐ Yes 2 X No		pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify:	
Baltimore, Maryland 21215-0036	within 72 hou giene. ter than "natu t, the Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (9-12)		(Give F life. D	lent's Usual Occup kind of work done of O NOT use retired) Unting		king	16b. Kind of Busines New York	s/industry State Schools
land 2	uld be filed wi Mental Hygi narked other latic event, t	Be	17. Father's Name (First, Middle, Last) Edward Dietrich				18. Mother's Nar Gertrude		Maiden Surname)	
, Mary	age 1 and 2 should be ont of Health and Ment: It: If item 27 is marked y or other traumatic e	1 1	19a. Informant's Name/Relationship (Type David L. Ruppel -s						; City or Town, State, 2 Florida 32	
timore	G F E E		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	Removal from State Ca Is	lace of Dispo emetery, cren Verton	sition (Name of natory or other place National	e Cem.11/	^{Date} /7/2012	Long Islan	or Town, State ad, New York
Ball	permit. Departr Import any inji		21. Signature of Funeral Service License	Bagward	133 4	Name and Address Onald V. 400 Powde	Borgward	lt Funera Road Beli	al Home, Patrick, Market M The Market	A aryland 20705
	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition	lications wat caused the death e cause on each line. Arterioscle						Approximate Interval Between Onset and Death 20 years
	Medical Examiner		resulting in death)	Due to (or as a consequent Hypertensic	ence of):					30 years
2	executed in and ria feet	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Diabetes Me	ellitu	s-Type I	I			unknown
09	ate be exectly the purial the burial the bur		resulting in death) Last	Due to (or as a consequ	ence of):					
. Box 68760	requires that the death certificate be e been signed by the attending physicia should be detached for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of d 9 Unknown	I death 3	Ectopic pregnanc Other (specify)	су		23d. Date of d Month	elivery Day Year
ls, P.O.	uires that the name of signed by all de deta	ed by Pt	Part II. Other significant conditions co Paroxysmal Atrial	ntributing to death but not resu Fibrillation	ulting in the u	nderlying cause giv	ven in Part I.		bacco use contribute (es. 2 X No. 3 \Box	to the cause of death? Probably 4 Unknown
Division of Vital Records,	The law ate has page 2	Completed by						24a. Was a autop perfor	rmed? prior to	utopsy findings available completion of cause of
ita	ysician: The ils certificate I director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	ace of Death (Che			
n of V	ding Phys th. After this funeral di	cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 2 28a. Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	28c. Injury	4 LA Nursing F y at		ence 6 Other (Speow injury occurred	ecify)
Divisio	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				28f. Location (S City or Tow	treet and Number or R n, State)	lural Route Number,
_	the Hospital or thin 24 hours afte the Funeral Dire mpletely filled in	Medical	(Check 2 Medical Examin	ician: To the best of my knowle ner: On the basis of examination e Practitioner: To the best of m	and/or invest	igation, in my opinio	on, death occurred	at the time, date a	nd place, and due to the	e cause(s) and manner stated
	20		29b. Signature and title of certifier	emmel	OCRI	29c. License	e number	7	29d. Date signed (Mo)	ith, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eileen Gemmell, CRNP 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year)

OCT 31 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:04 AM ANNA ROSEN 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Prince Georges 4b. City, Town, or Location of Death Examiner Hyattsville St. Thomas More Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Magey) Pand Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Augnth, Pay, Yel 1913 Days Min. 1 □ M 2 🔽 F 99 214-48-5780 Yrs Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Hyattsville Prince Georges Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States Funeral 20782 4922 LaSalle Road should be filed within 72 hours after death and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. , 01 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname)
Tillie Oshinsky 17. Father's Name (First, Middle, Last) Moses Apple မ 9a. Informant's Name/Relationship (Type, Print) Beverly Ervin, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other. 6930 - 74th Street, Bradenton, FL 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Lebanon Cemetery 10/28/12 Adelphi, MD ture of Funeral/Solvice Licensee Formoheinskys Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Par 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SYSTEMIC INFLAMMATURY ROSPONSE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ fo Day Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA ADUMNCED Records, 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed ATHEROSCLEROTIC CORONARY ARTENY 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 page 2 s prior to completion or death? 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practices. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practices. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 072/68 0/26/2012 M·D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

ROBERT MCNENDO 4912

31

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

acked

LASALLE ROND HYNTTSVILLE MANYLAND 20182

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MEND#23a(a-c)perCOME, 11/7/12; EMW, McGertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rivas Lemus Physician/ Month Faustino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Ball hore Examiner 4c. County of Death (tospital Pkins 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Country None Director 1 **⊠** M 2 □ F vadbi ertment of Health and Mental Hygiene. ortant: If Item 27 is marked other then "netural", or Items 23a or 28a-f show Injury or other treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 6 alvador 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black. White, etc. 1 KN Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 No 2 No If Yes Give 3 Widowed 4 Divorced Completed Jadorian Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired). Elementary/Secondary (0-12) College (1-4 or 5+) ndscapin 1 and 2 should be filed with f Health and Mental Hygien Item 27 is marked other th Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) davahter permit. Page 1 and 2 Der ertment of Health Important: If item 2, any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the discussy, or complications that caused the death. Do not enter the mode of dying, such as coverage factor respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate cause on each line. Complications of Chronic Alcohol Abuse Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury ettending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): WED BY MEDICAL EXAMIN Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day 4 Pregnant 9 Unknown Pregnant at time of death ed by the e 1 Yes 2 L 9 Unknown cate has been signed to page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physicien: The law requires t within 24 hours after death.
To the Funerel Firector, After this certificate has been sign completely filler in by the funeral director, page 2 should be completely filler in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performe 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: Yes 2 No 잍 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely f 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) cto Der 26, 2012 ress of person who completed cause of death (Item 23a) (Type, Print) 800 Orleans St. Baltimore MD an 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 06-2011

Registrar

0CT

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) Bonny Lea Shepherd 4a. Facility Name (if not institution, give street and number) Western MD Health System Cumberland 5. Social Security Number 2. Date of Death Month Day 2012 1327 4b. City, Town, or Location of Death Western MD Health System Cumberland Allegany 5. Social Security Number 214-36-7003 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10d. Inside City Lire	ı	1 - For State Registrar		aryland / Dep	ndelible in eartment of F ertificate of L	Health and I	Mental Hyg	_	12 3805
Total Part Section of Number Section S	ledical	Bonny Lea She	pherd				2. Date of Dea Month	th Day	012 1327
The Social Sociality Number 10 Sees 17 App (myr. na brunches) Planter 1 West 10 Sees 10 Sees of the Sees	miner		· · · · · · · · · · · · · · · · · · ·	em				1	
100 Date 100	_	5. Social Security Number 214-36-7003	. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	(Month, Day	; Year)	Birthplace (State or Fore Country)
23a. Pail 1; filter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between consistent and Death of the Control o	med at ector	10a. State 10b. County				<u> </u>		,	10d. Inside City Lim 1 Yes 2
23a. Pah 1 Method (sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Ust only one cause on each line. Interest Between constant and Death Cause of the Control of Cont	ral Dir	10e. Street and Number	_		10f. Zip Code				Vhat Country?
23a. Pail 1; filter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between consistent and Death of the Control o	d by Fune	11. Marital Status 1 ☐ Never Married 2 Marrie	12. Was Decedent E- Armed Forces? 1 Yes 2	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	in, Mexican, Puerto	ecify Yes or No-	14. Race Blac	k, White, etc.
23a. Pah 1 Meth the disease, of-complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Ust only one cause on each line. Interval Between chast and Death of the cause of cause	e meaical E omplete	15. Decedent' (Specify only highest	s Education grade completed)	(Give	kind of work done of		ing		white
108 Virginia Ave	To Be C	17. Father's Name (First, Middle, Las	t)	<u> tran</u>	sistor a	18. Mother's Nam	ne (First, Middle, N	Maiden Surname	
23a. Pah 1 Meth the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between chest of the death of the	ner trauman	19a. Informant's Name/Relationship Paul Shepher				and Number or Rur	al Route Number,	City or Town, S	
23a. Pah 1. Infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between diseases or contributing in death Due to (or as a consequence of): Consequence of the contributing in death Due to (or as a consequence of): Contributing in death Due to (or as a consequence of): Contributing in death Contrib	njury or ou	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	cemetery, cre	matory or other place Mem Par	k 11/			
Sequentially list conditions, if any, leading to immediate cause final ending of cause in resulting in death) Sequentially list conditions, if any, leading to immediate cause final ending cause given in part life past 12 pointing in death). But very that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as	once	1 (March	1111	1	08 Vira	S inia Av	e. Cumb	perland	eral Home 1,MD21502
Sequentially list conditions in mismediate cause. Enter Underlying Last Underl	ical	Immediate Cause (Final disease or condition	y one cause on each line.	osis of		,	or respiratory arre	;;;	Interval Between Onset and Deat
FEMALE: 23b. Was decedent pregnant in the past 12 mpnths? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Wes 2 No 9 Unknown 23d. Date of delivery Month Day Year 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 2 24b. Were autopsy findings availar performed? 1 Yes 2 No 1 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2	a	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
226. Did lobacco use contribute to the cause of death 226. Did lobacco use contribute to the cause of death 224a. Was an autopsy performed? 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of injury 28b. Time of injury 28b. T	cian/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 W No	23c. If yes, outcome c 1 ☐ Live Birth 2 4 ☐ Pregnant at	2 Fetal death 3		у			
25. Was case referred to medical examiner? 1 Yes 2 No No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 1 Natural 2 No 28a. Date of Injury - At home, farm, street, factory, office 28b. Time of injury 28b. Time of inj	Ď		contributing to death bu	ut not resulting in the	underlying cause giv	ven in Part I.			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of injury 3 Suicide 4 Homicide 28a. Date of Injury 4 Suicide 4 Homicide 28a. Date of Injury 4 Suicide 4 Homicide 28a. Date of Injury 5 Pending 1 Natural 2 Suicide 4 Homicide 28a. Date of Injury 6 Suicide 6 Could not be determined 28b. Time of injury 8 Suicide 9 Suicide 9 Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and dile of sertifier 29c. License number 29d. Date signad (Month, Day, Year) 28d. Describe how injury occurred 28d. Describe how injury occur	Complete						autops perfor	med?	rior to completion of cause leath?
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 Yes 2 No 28c. Injury at work? 1 Yes 2 No 28c. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred 28d. Describe how i	િ Be	examiner?	Hospital:	nt 2 X ER/Outpatie		er		ence 6 \(\text{Othe}	er (Specify)
29a. Certifier 1 **XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 **Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)		1 Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day,	y Yea <i>r</i>) 28b. Time o Injury	f 28c. Injury work M 1 \square	/ at ?	28d. Describe ho	w injury occurre	od .
D0023371 11/5/2012	cal Cert	4 Homicide determine	ed 28e. Place of Injur building, etc.	(Specify)		data and since	City or Towr	n, State)	
D0023371 11/5/2012	Medic	(Check 2 Medical Exa only one) 3 Certifying N	miner: On the basis of ex	amination and/or inves	stigation, in my opinio e, death occurred at the	n, death occurred a he time, date and pl	t the time, date an ace, and due to th	d place, and due e cause(s) and m	to the cause(s) and manner s anner as stated.
		30 Name and address of reals	o completed season of the	ath (Item 23a) (Time	DOG Print)	23371		11/5/	2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical KTONE 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Inpatient Care Center Harwood 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) District 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 578-48-3591 78 1 🕅 M 2 🗆 F Aug. 27,1934 Columbia Usual Residence of Page 1 and 2 should be filed within 72 hours after death with the Maryland innent of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-1 show iury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director White Stone Lancaster VA 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 101 Winona Drive 22578 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔯 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highe st grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Aero-Space 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Louise Dorr Campbell Troxell Smith, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1764 Hickory Trail Annapolis, MD 21401 19a. Informant's Name/Relationship (Type, Print) Scott Smith / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 01 permit. Page 1
Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore, MD Metro Crematory, INC 2012 21. Signature of Furneral Septica Licensee 22. Name and Address of Facility CREMATION DIRECT MD 21146 495 Ritchie Hwy Severna Park, Approximate
Interval Between
Onset and Death
USE CKS-XIVI 1. Enter the disease, or complications that caused rock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed enents Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day the detached 9 Unknown 9 | Linknown Division of Vital Records, P.O. ate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 Yes 2 No Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bigcirc Other (Specify) \bigcap عِ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After ' 28d. Describe how injury occurred 1 Natural 5 Pending death. ☐ Accident 1 Yes 2 No Investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely To the within 2 3 💢 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 07

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:45 a.M. Detobe FRIEDA SCHELLHASE 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEL GLEN BURNIE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 1 M 2 F 213-18-3100 BALTIMORE 91 8/6/1921 Usual Residence of Decede 27 is marked other than "naturel", or items 23a or 28e-f shov treumatic event, <u>the Medical Examiner must be notified at</u> 10a State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 TNo MARYLAND ANNE ARUNDEL SEVERNA PARK 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 389 SOUTH DRIVE 21146 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 ☐ Yes 2 🖾 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by iled within 72 hours efter Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: WHITE 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) RESTAURANT PROPRIETOR RESTAURANT æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 end 2 should be WILLIAM GAUSE SOPHIA BIRX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 ROBERT SCHELLHASE/SON 389 SOUTH DRIVE, SEVERNA PARK, MD 21146 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Importent: If it cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PARKWOOD CEMETERY 11/5/2012 BALTIMORE, MD permit. Name and Address of Facility LASTING TRIBUTES BY FELLOWS LFENBEIN & NEWNAM CREMATION & FUNERAL CARE 14 BESTGATE ROAD, ANNAPOLIS, MD 21401 21. Signature of Euneral Service Lig Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence f): il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and 27 eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Dav Year 9 Unknown 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Tes 2 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 7. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) mo DGODEN 30. Name and address of berson who completed cause of death (Item 23a) (Type Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Da)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29, 2012 Loise Szelesi 1:45P Ellen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Univ. of MD Medical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Min Days Hours 056-48-1122 **Director** 1 M 2 X F 59 1/21/1953 New York 28a-f shov 10a, State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland Temple Hills 1 🗌 Yes 2 💢 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 Funeral 4707 Tamworth Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XNever Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗎 Divorced White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Flooring Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 F. Louis Kiefer Helen Rutsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health aitem 27 i Susan Hall/Personal Rep. 1295 N. Osage Rd., Mulvane, KS 67110 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 11/1/2012 Edgewater, Maryland 4 Donation 5 Other (Specify) uneral Service Licen 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature 6160 Oxon Hill Rd., Oxon Hill, MD 20745 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physiciani Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month signed by the at d be detached for Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: ျ 1 Yes 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who co Sarah Sammons 2

NOV 0 1 2012

31. Date filed (Month, Day, Yea

22 S. Greene Street, Baltimore, MD 21201

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1215203013

10/29/2012

			State of Maryland / Dep		Mental Hygie	ene . N. 2012	38061
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg	J. No. C U I C	
	Physicia Medic		Frank Macey Speaks, Jr.		October 2	26 ^{ay} , 201 ² 2 ^{ar}	3. Time of Death 11:53 P M
1	Examin		4a. Facility Name (if not institution, give street and number) 629 Harbor Drive	4b. City, Town, or Location of Death Annapolis	h	4c. County of Death Anne Aru	ındel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		9. Birtho	lace (State or Foreign
	Director	2	214-26-2841 1 対 M 2 □ F 83 Yrs.	Months Days Hours Min.	(Month, Day, Ye 10/18/19	ear) Coun	
pud	show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le			1	0d. Inside City Limits
Mary	28a-f notified	irec	Maryland Anne Arundel	Annapolis			1 X Yes 2 No
with the	23a or st be r	Funeral Director	10e. Street and Number 629 Harbor Drive	10f. Zip Code 21403	10g	g. Citizen of What Coun USA	try?
death	items		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
036 saffer	ral", or Exami	ed by	1 ☐ Never Married 2 🕱 Married 1 🛣 Yes 2 ☐ No 1f Yes, Give Year or Dates. 48-52	1 ☐ Yes 2 🗷 No Specify:	,	Specify: White	
5-0 2 Polit	"natu	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of work	rking 16	6b. Kind of Business/Inc	dustry
2121 Within 7	iene. sr than the M		Elementary/Secondary (U-12) College (1-4 or 5+)	of Employee Relat	ions U	SNA Civil S	Service
Maryland 21215-0036	of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, Main		
aryla guid by	nd Men mark matic	_	Frank Speaks 19a. Informant's Name/Relationship (Type, Print) 19b. Mail				'adel
, Ma	n 27 is n 27 is er trau		Joan Speaks - Wife 629	ng Address (Street and Number or Ru. Harbor Drive, Ann	napolis, M	D 21403	
Baltimore,	nent of He ant: If iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cre Hillcres	matory or other place)		oc. Location - City or To Annapolis,	
Balti	Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	2. Name and Address of Facility $J_{\rm C}$			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each rine.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	, i. i. n Medical	i q	Immediate Cause (Final disease or condition resulting in death)	lia			Onset and Death
	xaminer		Due to (or as a consequence of):				,
pe	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Disease or injury)				
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certific	anding use as	M/us	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of delive	ery
). Box the death of	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me		Other (specify)		Month	Day Year
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ords requir	been s	letec	HyperTension	,	24a, Was an		osy findings available
Vital Records, ysician: The law requires	s certificate has b director, page 2 s	Completed by	1) 7 per rension,		autopsy performe 1 \(\superset \text{Yes}\) 2	prior to col death?	mpletion of cause of
Ital sician:	certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient	26. Place of Death (Chec	ck only one)		
OT V	ter this	te: To	27. Manner of Death 28a. Date of injury 28b. Time C	nt 3 L J DOA 4 L Nursing H	lome 5 KResidence 28d. Describe how i	e 6 Other (Specify)	
SION ttendir	death. tor: Af / the fu	Certificate:	2 Accident Investigation	M 1 Yes 2 No			
DIVISION OF tal or Attending Ph	irs after al Direc led in by		4 Homicide determined 28e. Place of Injury - At home, farm, st bullding, etc. (Specify)	eet, ractory, office	City or Town, S	et and Number or Rural State)	Route Number,
) he Hospi	within 24 hours after death. To the Funeral Director. After this certificate I completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation.	stigation, in my opinion, death occurred	at the time, date and p	place, and due to the cau	ise(s) and manner stated.
			29b. Signature and title of certifier M-D	29c. License number 965	29d	Date signed (Month, I	Day, Year)
B	KOX		30. Name and address of person who completed cause of death (Item 23a) (Type,	11	malis	W/ 2/4	26 1
	Stat Registra		31. Date filed (Month, Day, Year) NOV 01 2012 32. Fegistrar's Signature	harl	1		<u>. </u>

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 2 3 3 5 5 2											
	Physicia	n/	1. Decedent's Name (First, Middle Gertrude Eliz	. ,	1tor				2. Date of De	eath	3. Time of Death		
	Medic Examin	al	Gertrude E112 4a. Facility Name (if not institution Dorchester Ger	, give street and numbe	r) .		4b. City, Town			4c. County of D	eath		
	Funeral		5. Social Security Number		Age (In yrs. la		If Under 1 Ye Months Day		24 Hrs. 8. Date of Bir	Dorch 9.	Birthplace (State or Foreign Country) New York		
1	Director		081-10-8814 Usual Residence of Decedent 10a. State 10b. County		96	Yrs.	etion		April	20, 1910 I	10d. Inside City Limits		
\$	Marylan 28a-f sh otified a	recto		hester	Toc. City	y, TOWN OF LOC		ridge			1 ☐ Yes 2 🔀 No		
22	with the 23a or 2st be no	Funeral Director	10e. Street and Number 5706 Glasgow	Court			10f. Zip Cod	21613		-	J. Citizen of What Country? USA		
Showalter, Gertrude Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun		If You Give	s? x No	1 16a. Deced	fas Decedent of Yes, specify Co	No Specify:		14. Race - A Black, W Specify: V	white		
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ر 'ر' Many	2 should lith and Mand Mand Mand Mand Mand Mand Mand		19a. Informant's Name/Relations Judith Ann Show		ghter	1			er or Rural Route Number t, Cambridge				
Showalter, Baltimore, Ma	Page 1 and nent of Hea int: If item iny or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5	3 Removal from Sta	olace)	Date 10/28/12	20c. Location - City Delmar,						
5ho Balti	permit. 8 Departm Importa any inju		21. Signature of Funeral Service I	neral Home e, MD 2161									
	Pnysician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a	as a consequal as a consequal	MON () ience of):	(C)	lying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death		
Division of Vital Records, P.O. Box 68760	te be e. vysiciar ne buriż	Physician/Medical E	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	th 2 ☐ Feta nt at time of d	ncy	Ectopic pregn Other (specify)			23d. Date of Month	delivery Day Year		
cords, P.C	2 3S	Completed by P	Part II. Other significant condition Part DX YSMA Vein The	AH (IA)	but not res File B	- //	ation Car	given in Part	24a. Was	Yes 2 100 3 0	e to the cause of death? Probably 4 Unknown autopsy findings available to completion of cause of		
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sion of Vit	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate hat completed filled in by the funeral director, page	Certificate: To I	1	28a. Date of (Month, gation	injury Day, Year)	28b. Time of injury	28c. lr	njury at ork? ☐ Yes 2 ☐	No	how injury occurred			
Divis	ital or Al irs after al Direc		4 Homicide determ	building,	etc. (Specify,)	et, factory, offic		City or To	Street and Number or wn, State)			
	To the Hospital or A within 24 hours after To the Funeral Direct completed filled in by	Medical	(Check 2 Medical E	Physician: To the best examiner: On the basis Nurse Practioner: To	of examination	and/or investi	gation, in my op	oinion, death or	ccurred at the time, date	and place, and due to t	the cause(s) and manner stated.		
	with with Con		29b. Signature and title of certifie	Man Di O	,		29c. Lice	H461	5	29d. Date signed (Mo	onth, Day, Year) 8/12		
_	´)		Lais A NA	who completed cause of RR P (of death (Item	23a) (Type, P	int) B	Sram	ble SI	Cambo	ridge MD		
	Stat Registra		31. Date filed (Month, Day, Year) NOV 61	2012 37. Regi	strar's Signat	par par	Kel						

James Richard Sh	arps, Jr. State 1- For State Registrar	e of Maryland / D	epartment Certificate		nd Mental		2012	3806
Physician		ist)				2. Date of Dear	th	3. Time of Death
Medical Examine		os Jr				Month November	Day Year r 6, 2012	0354 hrs
	4a. Facility Name (if not institution, g			4b. City, Town, o	or Location of De		4c. County of Death	
	Anne Arundel Medical Ce	enter		Annapolis			Anne Arundel	
Funeral	Social Security Number 6. 8	Sex 7. Age (In	yrs. last birthday) If Under 1 Ye	ar If Under 24		th (MM/DD/YYYY) 9. Birt	
Director	214-31-3974	X M 2 F	24	Months Da	ys Hours M	Min. Sept	12 1988 co	Marvland
	Usual Residence of Decedent			1,3				77-1
*o	10a. State 10b. County	100	City, Town or Lo	cation				10d. Inside City Limits
* .	Maryland Anne A	Arundel	Annapo	lis				1 Yes 2 XNo
rrylar Sa-f s	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What Cour	itry?
the Maryland to 0.28a-f.sh tiffed at 90cc	204 Garden Gat	- Tama		214	102	l'	USA	,
ith th	11. Marital Status	12. Was Decedent Eve	n in 116 140	Was Decedent of H		Consider Wasses No.		- Latin Dint
er death with 1 , or items 23. r. must be not	1 X Never Married 2 Marrie	Armed Forces?		If Yes, specify Cuba			- 14. Race - Ameri White, etc.	can indian, Black,
er de	3 Widowed 4 Divorce	1 Yes 2 X		Yes 2X N	o specific		Specify: B	lack
ural"		or Dates:		dent's Usual Occup		of work done	16b. Kind of Business/li	
2 hou "nat	Elementary/Secondary (0-12)	College (1-4 or 5+)		g most of working lif			Tob. Tand of Basinessin	idustry
Hin 7	12th	0	C	ashier			Home Dep	ot
15-0036 Tiled within 72 hours after death with the Maryland Hyggene. d other that o "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at socc. the Medical Examiner must be notified at socc. the Medical Examiner must be notified at socc.	17. Father's Name (First, Middle, Las	t)			18.Mother's Na	me (First, Middle, I	Maiden Surname)	····
21215-0036 suld be filed within 7 Mental Hygiene. marked other than cevest, the Medica		os Sr			Tvies	e Hicks		
D 2121: should be fi and Mental R 7 is marked natic event, To Be			19b. Ma	iling Address (Stre			nber, City or Town, State	Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene. Not: If item 27 is marked other thato "natural", or items 23a or 28a-f short rother traumatic evect, the Medical Examiner must be notified at once To Be Completed by Funeral Director	James R. Sharp	s Sr(Fathe	er) 204	Garden	Gate I	ane Ann	apolis, M	d. 21403
e, MI I and 2 s Health a item 27	20a. Method of Disposition		20b. Place of Dis	position (Name of c rother place)	emetery,	Date	20c. Location - City or	Town, State
DOT ages nt of tt: If	1 X Burial 2 Cremation 3		Memori	al Park	11	-16-12	Annapoli	s, Md.
Baltimore, permit. Pages I ar Department of Hee Important: If ite ojury or other fr	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice				esef EstrilityC o	na Mart	uary, P.A	
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 iojury or other traum	Zarry & Bees						olis, Md.	
Physician	23a. Part I. E. ter the disease, or com	plications that caused the						Approximate Interval
/Medical	failure. List only one cause on e	each line.					,	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	Acute Asthm Due to (or as a conseque						- DOZIII
- 1		Due to (or as a conseque	5110 0 01).					
	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
ed asit	events resulting in death) Last	Due to (or as a conseque	ence of):					
ecu ecu	X UNPENDED	AMENDED23a,27	7 por mo	c022 11.	20 12 0			
	[A] UNPENDED	AMENDEDZ Ja , Z	, ber me	,g,,,, 11-	43-14 SI	u		
Box 68760, s death certificate be the attending physici of for use as the builthysician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		Fetal death 3	Ectopic pres		23d. Date of delivery	
certi endin use a	past 12 months?	4 Pregnant at time	2 U	Fetal death 3 Other (Specify)	Ecropic bre	griancy	Month D	ay Year
D. Box (true death ce by the attend ached for use	1 Yes 2 No 9 Unknow	n 9 Unknown	3 🗀	Other (Specify)				
that the d	Part II. Other significant conditions	contributing to death but	t not resulting in the	ne underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
res that signed be deta						1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
Division of Vital Records, P.O. ral or Attending Physiciao: The law requires that thers after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P						24a. Was	an 24b. Were au	topsy findings available
COT law r has b			-			_ autop		ompletion of cause of
tal Rections: The certificate ector, page						1 Yes		s 2 No
ital Rections: The certificate rector, page		Hospital:			ce of Death (Che			
Physical direction	1 Yes 2 No	T Inpution	2 KER/Outpati				Residence 6 Other	
ding Ph After t funeral		28a. Date of Injury (Month, Day,Year)	28b. Time	· · · ·	ury at Work?	28d. Describe I	now injury occurred	
Division pital or Attent ours after death ceral Director: filled in by the	2 Accident Pending	tion		1	Yes 2 No			
ior A Bire Jin b Life	3 Suicide 6 Could no		- At home, farm, s	treet, factory, office	building, etc.	28f. Location (\$ or Town, S	Street and Number or Ruitate)	ral Route Number, City
E S # E L C	4 Homicide determin	ed (Specify)				1		
E Fuc		cian: To the best of my kno						
To the Hos within 24 h To the Fuo completely	one) 2 Medical Examine	er: On the basis of examina and manner stated.	ation and/or invest	igation, in my opinio	on, death occurre	d at the time, date	and place, and due to the	e cause(s)
ع ا ا ا	29b. Signature and title of certifier	1			se number		29d. Date signed (Mor	th, Day, Year)
	Cle of	11 CCCC a	(U	0.0	.M.E.		November 7, 201	2
_	30. Name and address of person who	completed cause of death	ı (İtem 23a)					

State Registrar

31. Date filed (Month, Day, Year) 2012

Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, c. perFH, G938, 4/13/2013, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 8:05 A Edward Edwin Samuel Singletary October 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 18889 Waring Station Rd. #216 Germantown Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** South Carolina 251-70-7126 11/20/1942 1 ÅM 2 □ F Director 69 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. Coun 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Montgomery Germantown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 18889 Waring Station Rd. #216 20874 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ 1 X Yes 2 No
If Yes, Give 1960
Year or Dates. 1963 Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. 4 years Elementary/Secondary (0-12) 1 and 2 should be filed within the Health and Mental Hygiene item 27 is marked other the US Postal Worker US Postal Service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 9 Fredrick Singletary, Sr. Susie Gorham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 18889 Waring Station Rd. #216 Germantown, MD 20874 Girlena Gee Singletary - Wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Quantico National 1 X Burial 2 Cremation 3 Removal from State Triangle, Cem. 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee any MarlHunte 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner End Stage Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit Coronary Artery Disease Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Diabetes Hospital or Attending Physician. The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I I be del 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending X Natural Division 1 Yes 2 No Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the f Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD Nov. 1, 2012 D53365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA S. Wilson, M.D. 14804 Physicians Ln. #221 Rockville, MD 20850 31. Date filed (Month, Day, Year) State 0 Registrar nny

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 10 05AM Schildtknecht Katherine Margaret Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NMS of Hacerstown Hagers-lown If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 01/30/1921 1 🗆 M 2 🕱 F Months Days Hours **Director** 212-16-9177 91 Maryland Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits the Maryland at 10c. City, Town or Location Director or 28a-f si notified 1 Yes 2 X No Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r by Funeral U.S.A. 14014 Marsh Pike 21742 items Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene.
ant, If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕱 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Specify: White Completed 3 ☒ Widowed 4 ☐ Divorced Year or Dates intal Hygiene.

ced other than "natura cevent, the Medical E 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George W. Jones Iva Myrtle Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Schildtknecht / Son Brethren Lane, Hedgesville, WV 25427 Ronald A. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important; If ite any injury or oth Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 11/9/12 Rest Haven Cemetery Hagerstown, Maryland 21. Sign re of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Avenue, Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ OCONGCE 15c 451 disease or condition resulting in death) Medical Due to (or as a consequence f) Examiner 514 Sequentially list conditions it day, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital. 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6 125

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Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

CRUP 14014 Mush

Hagers town 21742

Pila

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar *Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 4, 20**1**2 4:05 A M William Samuel Sellers, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Golden Living Center Hagerstown **Funeral** . Age (In yrs. last birthday 1 Year If Under 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) 162-22-5761 Director 84 110 M 2 D F 01/16/1928 Chambersburg, PA Usual Residence of Decedent 23a or 28a-f show ist be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits by Funeral Director 1 XYes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 655 Forest Drive 21740 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2X No Specify 3 X Widowed 4 Divorced Specify: Completed Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools th Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Robert Sellers Amanda Jane Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17616 Stone Valley Dr., Hagerstown, MD 21740 <u>Deborah L. Johnson / Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 11/09/2012 Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home Signature of Funeral Service Licenses 305 N. Potomac St. Hagerstown, MD 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory affect shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Frysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and burial-trar that initiated events resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the k nse s 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birt 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has after death.

Director: After this certificate 1 Yes 2 No funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes 2 12 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 🗆 No Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Funeral hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I NOV

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DHMH 17 Rev 06-2011

30. Name and address of person who completed

ause of death (Item 23a) (Type, Print)

12-08242

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

racy Jay Senior	Certificate of Death	3806
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time Tracky Tay Seption Month Day Year	ime of Death 038 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 39531 Golden Beach Road 4c. County of Death Mechanicsville St. Mary's	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace Foreign Months Days Hours Min. May 8 1960 Metroly 1	
auth with the Maryland items 23a nr 28a-f show any ust be notified at once.	Maryland Charles Mechanicsville 10e. Street and Number 39531 Golden Beach Road 10f. Zip Code 20659 United States 11. Marital Status 1 XNever Married 2 Married Armed Forces? 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent In White, etc.	
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a ar 28a-faba traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Specify: WNITE 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A 16b. Kind of Business/Industr during most of working life. DO NOT use retired) N/A 17. Father's Name (First, Middle, Last)	ry
nore, MD 21215-0036 ges 1 and 2 should be filed within 72 at of Health and Mental Hygiene. T: If item 27 is marked other than in ther traumatic event, the Medical other Table To Be Comple	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Control of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, crematory or other place)	20659 n, State
Baltimore, permit. Pages 1 an Department of Hee Important: If ite injury or other trianger.	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Chesapeake Highlands Nov 5 2012 Port Republic 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20	.0676
Physician Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	proximate Interval atween Onset and Death
re executed cian and nrial - transit dical Exal		
D. Box 68760, the death certificate be by the attending physic rehed for use as the burn Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
P.O. ss that the gned by the detach	1 Yes 2 No 3 Probably	4 Unknown findings available etion of cause of
Vital Rechysician: The hysician: The lifector, page	25. Was case referred to medical 26. Mace of Death (Check only one) examiner? Hospital: Incentical 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scenario	2 No
Division of Vital Records, pital or Attending Physician: The law require ours after death. Beral Director: After this certificate has been si filled in by the funeral director, page 2 should be Certification: To Be Completed	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred	oute Number, City
Divisior To the Bospital or Attend within 24 bours after death To the Funeral Director: completely filled in by the Medical Certificatic	1 298 CENTILES	ise(s)
To To Cour	and manner stated. 29c. License number 29d. Date signed (Month, D. Correct #40 0 d and D.C.M.E. November 1, 2012	
	30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra		

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct 30 2012 2020 PM Sybil Mozelle Steele Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Dec 20, 1925 Arkansas Director 86 432-30-0919 1 🗆 M 2 🛣 F at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director or 28a-f sl notified Maryland Calvert St. Leonard 1 Yes 2X No 10g. Citizen of What Country?
United States 5 10e. Street and Number 10f. Zip Code ms 23a or must be 20685 Funeral 6425 Quarles Road "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: white Completed 3 😾 Widowed 4 🗆 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government secretary event, th it. Page 1 and 2 should be filed withment of Health and Mental Hygintrant: If item 27 is marked other ajury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary A. Elliott William J. Brantley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6425 Ouarles Rd. St. Leonard, MD 20685 John Robert Steele, Jr. - son 20a. Method of Disposition 20b. Place of Disposition (Name of 10/31/9912 Department of I Important: If it any injury or of once, 1 Burial 2 Cremation 3 Removal from State Metropolitan Funeral Service Alexandria Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA nture of Fune al Service Licensee 4405 Broomes Is. Rd. Port Republic, MD 20676 o not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications in a caused the death shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ue to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed? death? certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes ပ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of Date of injury 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours a Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number n 23a) (Type, Print) Road State Registrar

		-	For State	State of Maryla	-	artment of H <i>rtificate of D</i>			2016	2 38069
			Registrar 1. Decedent's Name (First, Middle, La.			Timodio o. B		2. Date of Death	J. No.	3. Time of Death
	Physicia Medic		Adele Mary	Spellerberg				October	25, 2012	
	Examin	er	4a. Facility Name (if not institution, give Friends Nursing H				Location of Death y Spring		4c. County of D Montg	
	Funeral		5. Social Security Number 6. S		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign
	Director			□ M 2 🖾 F 93	Yrs.	Months Days	Hours Min.	June 21,		Country) Ohio
	works show	or	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation		,		10d. Inside City Limits
	Maryla 1881-f Iffled	rect	MD Montgo	merv	Silver	Spring				1 ☐ Yes 2XCXNo
	a or 2	ΩE	10e. Street and Number			10f. Zip Code			g. Citizen of What	Country?
	th with	Funeral Director	15210 Elkridge		Lo Lio	20906			USA	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates.		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🔀 No	n, Mexican, Puerto	Rican, etc.)	14. Hace - A Black, W Specify: Wh	
5-0	72 hou	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occupa kind of work done d	ition uring most of work	ing 10	6b. Kind of Busine	ss/Industry
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Baltimore, Maryland 21215-0036	d be filed v Mental Hyg arked othe itic event,	To Be	17. Father's Name (First, Middle, Last) Andrew Misek					e (First, Middle, Ma eth Hudac		
, Man	nd 2 shoul saith end l n 27 is ma ier trauma		19a. Informant's Name/Relationship (1 Ruth Anne Spell			ing Address (Street a				Zip Code) pring, MD 20906
ore	ge 1 ar t of He If iter or oth		20a. Method of Disposition 1 2 Burial 2 Cremation 3			osition (Name of matory or other place		Date v. 02,	0c. Location - City	or Town, State
Ħ.	iit. Pac artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Special Service Liver)			leaven Cem	erery	2012 S	ilver Sp	
Ba	Depart Pering		Michaed L Ha	tes	1.5		sity Blv	d. W., Si	lver Spr	ing, Md 20901
F	nysician/	2 3	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.			, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death I Week
)	Medical Examiner		resulting in death)	a. Urinary Tra Due to (or as a conse	equence of):	CCLOII				1
	Lxammer	ē	Sequentially list conditions, if any, leading to immediate b. Ureteral Stone Due to (or as a consequence of):							3 mos.
	Pusit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conse	equence oi).					4
Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of):										
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687	ertifice ding p	/Me	IF FEMALE:	23c. If yes, outcome of preg	inancy				20d Data of	Matter
Division of Vital Records, P.O. Box 687	he death c y the atten ached for u	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d. Date of Month	Day Year
0.	s that t gned b be deta	þ	Part II. Other significant conditions of	contributing to death but not i	resulting in the	underlying cause giv	en in Part I.			e to the cause of death?
rds	s peen s	eted								Probably 4 Unknown
Reco	i: The law icate has b r, page 2 s	Completed	25. Was case referred to medical					24a. Was an autopsy perform	prior ed? death	autopsy findings available to completion of cause of n? Yes 2 No
/ita	/siciar s certii directo	To Be	examiner? 1 Yes 2 No	Hospital:	☐ FR/Outpatie	Othe	ace of Death (Chec	ome 5 Residen	ca 6 🗆 Othar (S)	naciful
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Certificate: T	27, Manner of Death 1 ANatural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	of 28c. Injury work	at	28d. Describe how		<i>Эесп</i> уу
Divisi	tal or Atters after de al Directo ed in by ti		3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined			reet, factory, office	eet, factory, office 28f. Location (Street and Number or Rural Route Ni City or Town, State)			Rural Route Number,
	he Hospit in 24 hour he Funer: ipletely fill	Medical	(Check 2 Dedical Exam	vsician: To the best of my kno niner: On the basis of examina se Practitioner: To the best of	tion and/or inve	stigation, in my opinio	n, death occurred a	it the time, date and	place, and due to t	he cause(s) and manner stated.
	10 6 d kit		29b. Signature and title of certifier	Brodul		29c. License	D45956	- 1	d. Date signed (Mo October 3	
	•		30. Name and address of person who Dawn Broderick,	MD 18111 Pri	nce Phi	lip Drive	, #201,	Olney, MD	20832	
	Sta Registra		31. Date filed (<i>Month</i> ; <i>Day</i> , <i>Year</i>) 6CT 31 20	32 Registrar's Sig	nature 4	arked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ October 20,2012 9:18P M <u>Stanley McClellan Sinkford.</u> Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bedford Court Assisted Living Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Days Hours 83 Yrs. Director West Virginia 233-34-8773 05/09/1929 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 ☐ No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3507 Tarkington Lane 20906 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. **African** Completed by 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates. filed within 72 hours after 2 No 1956 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Specify 1960 American of Health and Mental Hygiene. Item 27 is marked other than "natul other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pediatric Cardiologist Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stanley McClellan Sinkford, Sr. Marjorie Adams 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Craig Sinkford/Wife 3507 Tarkington Lane, Silver Spring, MD 20906 Department of Heah Important: If item 2 any injury or other once. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/30/12 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State Chesapeake Crematory 4 Donation 5 Other (Specify) Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service, of Funeral Service Licensee 7400 Georgia Ave., N.W. Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a donsequence of) **Examiner** Examiner law requires that the death certificate be executed the attending physician and Division of Vital Records, P.O. Box 68760 use as

Be Completed by Physician/Medical the Hospital or Attending Physician: The Inniu 24 hours after death.

the Funeral Director: After this certificate h completed filled in by the funeral director, Medical Certificate: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year	
Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown	
		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner?	26. Place of Death (Check of	only one)	
1 🗆 Yes 2 🖸 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5 Residence 6 Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 \(\text{Yes} \) 2 \(\text{No} \)	3d. Describe how injury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	ician: To the best of my knowledge, death occurred at the time, date and place, and		

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

within 24 hours a

To the Funeral D

0

State

only one)

30. Name and address of person

M.D who completed cause of grath (Item 23a) (Type, Print

Registrar's Signa

			_ State	State of Marylan		artment of H		Mental Hy	201	2 38071
	Dhyaiaia	/	Registrar 1. Decedent's Name (First, Middle, Last)	·		incate or b	Catir	2. Date of De	_	3. Time of Death
-	Physicia Medic	al	Timothy Doyle Stack					Month	26 201	2 2056 M
	Examin	er	4a. Facility Name (if not institution, give str Western Maryland Region		er	4b. City, Town, or Cumberla	Location of Death nd		4c. County of D	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th g.	Birthplace (State or Foreign Country)
4	Director	8	233-94-2909 1 X Usual Residence of Decedent	M 2 □ F 56	Yrs.	, ,		July 23,		aryland
	yland f shov ed at	tor	10a. State 10b. County		y, Town or Loc	ation	·			10d. Inside City Limits
	r 28a- notifie	Director	W Webster 10e. Street and Number	Cle	eveland	10f. Zip Code	-		40 000 5140	1 🗆 Yes 2 🛣 No
	with the 23a oust be	Funeral	131 Buffalo Run Road			26215			10g. Citizen of What United Stat	,
	death items ner m	Fun	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	S. 13. V	/as Decedent of His Yes, specify Cubar	spanic Origin? (Spo	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian,
036	s after al", or Exami	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates.		☐ Yes 2 🕅 No			Canaifu	hite
21215-0036	2 hour "natur	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	ent's Usual Occupa	ation	ina	16b. Kind of Busine	
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y aı	uld be I Menti narkec	입	Oscar Doyle Stack					th Herron		
Baltimore, Maryland	2 shouth and the sum traum	37.00	19a. Informant's Name/Relationship (Type	,					r, City or Town, State, n, WV 25414	Zip Code)
re,	1 and of Heal item		20a. Method of Disposition		lace of Dispos	sition (Name of		Date	20c. Location - City	or Town, State
ii.	. Page ment c tant: If		1 Durial 2 X Cremation 3 Re 4 Donation 5 Other (Specify)		thsburg (atory or other place Crematory	11/0	5/2012	Smithsburg,	
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fineral Service Licensee	"Pols	22.	Name and Address	s of Facility Jeff	erson Cha	pel Funeral n. WV 25414	Home
П			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of	ations that caused the deatl	n. Do not ente					Approximate Interval Between
	Physical Medical	8 4	Immediate Cause (Final disease or condition resulting in death)	Encept	alox	outhy				Onset and Death
	Examiner			Due to (or as a onsequ	ience of):					
		iner	Sequentially list conditions, if any learning to immediate cause. Enter Underlying Due to for as a consequence of the cause. Enter Underlying							
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					
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876	certificate be executed nding physician and use as the burial-transi		IF FEMALE:		-150111					
Box 687	requires that the death certificat been signed by the attending ph should be detached for use as th	Physician/Med	in the past 12 months?	 If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of outcomes 	l death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year
Ö.	the de	hysi	1 U Yes 2 U No 9 Unknown	g Unknown	- J	Other (specify)				
, P.O.	The law requires that the ate has been signed by the page 2 should be detach	<u>۾</u>	Part II. Other significant conditions contr	ibuting to death but not res	ulting in the ur	nderlying cause give	en in Part I.			to the cause of death?
rds	require been s should	Completed							1 Yes 2 No 3 Probably 4 Wunknown	
Records,	sician: The law requi certificate has been irector, page 2 shoul	dwo						autor perfo	24a. Was an autopsy performed 24b. Were autopsy findings ava prior to completion of cause death?	
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o u	tth. : After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🗀 \		28d. Describe h	ow injury occurred	
Division of	r Atter ter des rector by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,		et, factory, office		28f. Location (S City or Tow	Street and Number or	Rural Route Number,
á	pital o		200 Cartifus 1 V Cartifus Blands	1:			1			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check 2 L Medical Examiner	an: To the best of my knowler: On the basis of examination Practitioner: To the best of m	and/or investi	gation, in my opinior	 death occurred at 	the time, date a	ind place, and due to the	ne cause(s) and manner stated.
	Voithi Cong		29b. Signature and title of certifier	min		29c. License	number		29d. Date signed (Mo	nth, Day, Year)
	100		70-		00-1/7		51398		10	26 2012
	, 9,		30. Name and address of person who com Dr. James Shero 1250	pleted cause of death (Item O Willowbrook R			21502			
	Stat	-	31. Date filed (Month, Day, Year)	32. Registrar's Signat			 -			
	Registra	r	NOV 2 6 2012	Brun G. S	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Twigg Franklin Ronald 2036 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Allegan umber and Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number Age (In yrs. last birthday) **Funeral** Hours 220-30-8778 1 🕅 M 2 🗆 F 76 **Director** Maryland 12/22/1935 Usual Residence of Decedent shov 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County the Maryland must be notified at Director 28a-f 1 🕅 Yes 2 🗌 No MD Allegany Cumberland 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? ō by Funeral USA with 23a 21502 120 Mullen Street th and Mental Hygiene. 27 is marked other than "natural", or items: traumatic event, the Medical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No 1953If Yes, Give Black, White, etc. 1 Never Married 2 Narried permit. Page 1 and 2 should be filed within 72 hours after 1 Tes 2 No Specify White Specify: 3 Divorced 4 Divorced Completed 1956 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Union Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Grace Bishop Genevieve Franklin Twigg John 19a. Informant's Name/Relationship (Type, Print)
Margaret Louise Twigg/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Mullen Street, Cumberland, MD 21502 f Health other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō 0 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once, Vet Cem @ Rocky Gap 11/07/2012 Flintstone, MD MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Slonature of Funeral Service 404 Decatur Street, Cumberland, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Exter the disea Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ cute disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) labetes and trar that initiated events Due to (or as a consequence of) resulting in death) Last burial attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) detached for in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No .the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 Tes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 page 2 certificate funeral director, after death. Director: After this the filled in by

Baltimore, Maryland 21215-0036

25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 D No 1 🔲 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Investigation Accident 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

within 24 hours a

To the Funeral C

completely filled the 2 3+1 IUA

State Registrar

Be

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Certificate:

Medical

29a. Certifier

only one)

		mowledge, death occurred at the time, date and place, and o	
		29c. License number	29d. Date signed (Month, Day, Year)
Jain	MD	D70131	November 3, 2012

and due to the cause(s) and manner stated

Name and address of person who c

	(I) (CC -) (CC D.(-1))			
	(Item 23a) (Type, Print)	-		
12500	Willminbanak	Road	County land	MD-21502
(1300	- Inclosed Old	"I CCADI	CONTRACTOR	

29b. Signature and title of certifier

2 Medical E

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	1 - State Registrar Certificate of Death Reg. No.								
	Physicia Medic	al	1. Decedent's Name (First, Middle, Last) KATHLEEN PATRICIA THORNTON 2. Date of Death Month 10 Day 31 Year 12 920 A M 4b. City, Town, or Location of Death 4c. County of Death								
	Examin	er	BAUTIMORE WASHINGTON MOSICAL CENTER GLEN BURNIE, MB ANNE AFUNDEL								
	Funeral Director		5. Social Security Number 215-64-6186 6. Sex 1								
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Crofton 10g. Citizen of What Country? 10g. Citizen of What Country?								
	h with ns 23a nust b	neral	2408 Vineyard Lane 21114 USA								
9600	ırs after deat Jral", or iten I Examiner I	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Notorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Notorced 13. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 Notorced 14. Race - American Indian, Black, White, etc. 1 Yes 2 Notorced 15. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes, Give								
1215-0	ithin 72 hou ene. r than "natu t he Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ years 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Community Mediator 16b. Kind of Business Industry P.G. County								
Baltimore, Maryland 21215-0036	d be filed w Mental Hygi arked other	To Be	17. Father's Name (First, Middle, Last) Martin J. Thornton 18. Mother's Name (First, Middle, Maiden Surname) Annabelle Goldsmith								
, Mar	1 and 2 should be of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Samuel E. Long/ Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Pride of Baltimore Dr., Arnold, MD 21012								
timore	permit. Page 1 a Department of H Important; If ite any injury or ott		20a. Method of Disposition 1								
Bal	Depar Impol any ir		21. Signatur Fineral So fe y fee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037								
-	Physic Land Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Onset and Death								
*	Examiner	Jer	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):								
	ificate be executed ig physician and as the burial-transit	al Examiner	cause. Enter Underlying Cause (Usease or infjury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
8760	ficate b g physid as the b	Medical	d								
Box 68	The law requires that the death certi ate has been signed by the attendin page 2 should be detached for use:	Physician/N	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow								
ls, P.O.	v requires that th s been signed by should be detac	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X yes 2 No 3 Probably 4 Unknown								
Division of Vital Records,	sician: The law req certificate has bee lirector, page 2 shoi	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No								
/ita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Xes 2 No Hospital: 1 Inpatient 2 Reprodupation 3 Doal Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
on of \	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate: To	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred								
Divisi	ital or Atte urs after de ral Directo		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	ne Hosp n 24 hou ne Fune pleted fil	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	With to the total of the total	_	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DC S/SNAM M - D. 0 0 69146 10/31(2012)								
;	30		DR DISMAND M.D. DOO 69146 10/31/2012 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL SHAND, MD 301 HOSPITAL DR GLEN BURNIE MD 21061								
	Sta Registra		31. Date filed (Month, Day, Year) NOV 01 2012 32. Registrar's Signature								

12-08488 Sharon Diane Thay		of Maryland / Departi	elible Ink. Ensure A		egible.	3807
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		icate of Death	2. Date of De		3. Time of Death
Medical Examine	Sharor 4a. Facility Name (if not institution, give	Diane Thayer street and number)	4b. City, Town, or Locat		Day Year er 9, 2012 4c. County of Death	0749 hrs
	Union Hospital	17	Elkton	Lister Office To Date of B	Cecil	
Funeral Director	5. Social Security Number 6. Sex 212-88-4060	7. Age (In yrs. last I		lours Min	Foreig	hplace (State or n Virginia untry)
w any	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location			10d. Inside City Limits
Maryland 28a-f shnw d at once. ector	Maryland Cecil 10e. Street and Number		Conowinge		10g. Citizen of What Cour	1 Yes 2 No
The state of the s	1316 Liberty Grov	e Road 12. Was Decedent Ever in U.S.	2	1918	U.S.A.	
er death with , or items 23 r must he no Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	kican, Puerto Rican, etc.)	White, etc.	lhite
nurs afte	3 X Widowed 4 Divorced 1 15. Decedent's Education (Specify only	f Yes, Give Yeer or Dates: v highest grade completed) 16	1 Yes 2 No spe	Give kind of work done	16b. Kind of Business/I	ndustry
5-0036 od within 72 hours afted within 72 hours afted bygiene. he Medical Examine Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+) Two Year's	during most of working life. DO I	,	Oblates St DeSales, E	
MD 21215-0036 ad 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked nither than numatic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last)	McCracken		other's Name (First, Middle		TROOMS 110
5 212 hould by and Ment is mark	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailing Address (Street and	Number or Rural Route Nu	ımber, City or Town, State	
e, MI L and 2 s Health a item 27	Brandon F. Thayer	20b. Plac	1316 Liberty Gr		20c. Location - City or	21918 Town, State
Baltimore, permit. Pages I ar Department of Her Important: If ite	1 Burial 2 X Cremation 3 4 Donation 5 Other Specify:	Removal from State R.A.	natory or other place) Ferris & Co.,Inc		West Ches Pennsylva	nia
Balt permit. Depart Import injury	21. Signature of Funeral Service License	411.	22 Name and Address of Fa Lee A. Patte	rson & Son F Maryland 21	uneral Home,	P.A.
Physician /M i l	23a. Part I. Enter the disease, or compile failure. List only one cause on each	n line.				Approximate Interval Between Onset and Death
Examiner		iypertensive At. ue to (or as a consequence of):	herosclerotic ca	ardiovasculai	Disease	Deatri
her		ue to (or as a consequence of):				
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):				
executed ian and ial - transi	d. X UNPENDED	AMENDED 23a,pt.II	,27,per me,g934	12-6-12 sm		
760, ficate be g physic sthe bur	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnand		atazia arazana.	23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, ral not stending Physician: The law requires that the death certificate be exects after death. **I Director: After this certificate has been signed by the attending physician at led in by the funeral director, page 2 should be detached for use as the burial - rertification: To Be Completed by Physician/Medica	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ec	ctopic pregnancy	Month [)ay Year
P.O. res that the signed by the detach	Part II. Other significant conditions of Diabetes Mellit		ting in the underlying cause given		tobacco use contribute to es 2 No 3 Prot	
Records, P.C. The law requires that ficate has been signed . page 2 should be deg.					ppsy prior to d	topsy findings available ompletion of cause of
Rec : The la ifficate h	25. Was case referred to medical		20.0	1 ✓ Yes	ormed? death? 2 No 1 ✓ Ye	s 2 No
f Vital Physician or this certi ral director		spital: 1		eath (Check only one) 4 Nursing Home 5	Residence 6 Other	:
on of nding P. th. :: After e funera ion: 7	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Dey,Yeer)	b. Time of Injury 28c. Injury at \		how injury occurred	
Division o spital nr Attending hours after death. neral Directur: Aft filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e Place of Injury . At home	, farm, street, factory, office buildin		(Street and Number or Ru State)	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Inspital ar Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directur: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner:	n: To the best of my knowledge,	death occurred at the time, date an or investigation, in my opinion, deat			
A S E S O	29b. Signature and title of certifier	The mention stated.	29c. License nun		29d. Date signed (Mo	
	30. Name and address of person who co	mpleted cause of death (Item 23a	O.C.M.E.		November 10, 20) 1 Z

barker

Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Viola Physician/ homas 8:17 A.M. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Queen Hnne Hills Nursing Catr entreville 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Country) Maryland 1 M 2 KF Hours Month, Day, June 15, Director 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10d Inside City Limits Funeral Director Chester 1 X Yes 2 No Queen Anne 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 2161 USA tarlev 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Senior ashier Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ Ford 21658 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Acre Lane Queenstown nelma Kustic Brown 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once, 11/3/2012 Queenstown, MD rmichael Cometer 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility uneral Home, P.A. . Signature of Funeral Service Licensee C. ambridge, MID 51. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset/appl Death Immediate Cause (Final eretarisalor Or Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examiner Due to lor as a consequence of cause. Enter Underlying • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 2 🗌 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director. Be Hospital Other: 2 1 ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tes 2 🗌 No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of d D35 136 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per D. Dont Drive Ch 2108 ے کہ 2. Registrar's Signature State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Paul E. Thomas October 2012 6:05 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Wicomico 7290 Walston Switch Rd Parsonsburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) Director 213-24-2372 1 XM 2 □ F 84 06/27/1928 Maryland Usual Residence of Deced Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Model Examirer court terrout at 10h Count 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Wicomico Parsonsburg Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? by Funeral 21849 USA 7290 Walston Switch Road . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sign Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Kathleen McCready Preston E. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul E. Thomas/Son 2902 Merritt Mill Rd., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State permit, Page Depertment Important: If eny Injury or 4 Donation 5 Other (Specify) 10/8/2012 Salisbury, MD Wicomico Memorial Park 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): for use es the burlel-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day ate has been signed by the a page 2 should be detached t Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant donditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autoosy 1 ☐ Yes 2 110 1 Yes 2 DING To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No 2| 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suícide
4 Homicíde M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Me Mal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. nurse ،ctitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 296. Signaly wo erson who completed gause of death (Item 23a) (Type, Print) 76315 5THE MAN motestin

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38077 State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 6 2012 Physician/ 6:55 Doris Eleanor Tichenor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Emeritus Senior Living 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday, **Funeral** (Month, Day, Year, Months Davs Hours 577-20-6504 92 Director Feb. 28,1920 1 □ M 2 🕅 F Maryland 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21742 20009 Rosebank Way Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Co. Executive Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Georgiana Koons Alvah E. Young and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Noblewood Ct. Frederick, MD 21702 item 27 Cynthia L. Wood-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 11-8-2012 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hadensive Physician/ disease or condition resulting in death) Due th (or as a consequence of) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death cerificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ည 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 7. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 🖪 Natural 5 Pending injury Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [To the P 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kahlid Waseem 1126 Opal Court, Hagerstown, MD 21742 31. Date filed (Month, Day, Year) Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year \mathbf{p}^{M} November 5:58 Brightmoore Medical Thompson 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death La Plata Charles Civista Medical Center Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral Director** 223-54-8247
Usual Residence of Deced 1 🛛 M 2 🗆 F 70 June 11,1942 Virginia 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 ☐ Yes 2X No Maryland St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a Examiner must be Funeral USA 30380 Pine Street 20622 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 X Married "natural", or þ 1 ☐ Yes 2 X No Specify. Specify:White Maryland 21215-003 3 Widowed 4 Divorced Completed th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Program Director Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည e 1 and 2 should be of Health and Menta Robert G. Thompson Katherine F. Branch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 30380 Pine Street, Charlotte Hall, MD 20622 Bonnie S. Thompson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/09/2012 Hyndman, Pennsylvania Signatule of Funeral Service Licensee 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 MOO817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Qnset and Death Immediate Cause (Final Physician/ Pulmonar disease or condition eur5 Medical resulting in death) Due to (or as a consequence of Examiner f. Atrial Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, Hupulyp, The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE. 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Colit 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed No this certificate 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer 1 Natural 5 Pending injury work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29d. Date signed (Month, Day, Year) 11/21

DHMH 17 Rev 06-2011

State

Registrar

MD

32. Registrar's Signatur

12070 Old Line Cer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2012 2:55 AM Ann Marie Voat Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Severna Park **Examiner** 4c. County of Death 493 Derby Court Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 22, 1948 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) New York 150-38-7087 Director 1 🗆 M 2 🛣 F 64 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo Severna Park MD Anne Arundel 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 493 Derby Court 21146 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. 1 Never Married 2 Married 2 ☐ Yes 2 X No 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White 3 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Merchandiser Greeting Cards 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK မ 8 Haakon Strand Margrethe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 493 Derby Court Severna Park, MD 21146 Michael Voqt / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 02 Baltimore, MD Metro Crematory, INC. 2012 Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 any 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Small Cell Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the a should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physiclan: director. 25. Was case referred to medical of Vital æ 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XINO မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Division within 24 hours after death.

To the Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 29b. Signature and title of certifier 29c. License number pleted cause of death (Item 23a) (Type, Print) Name and address of person who co 2002 Medica 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 12 Physician/ 1000AM Lee Vulgamott, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mash MSol ageist STOWN ager If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
May 27, **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace State or Foreign **X** M 2 □ F Mary land 1923 Director 215-14-2819 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2X No PA Franklin Wavnesboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3370 Clay Hill Road 17268 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 🔯 Yes 2 🗌 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", If Yes Give White 3 Widowed 4 Divorced Year or Dates. f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ Susan Sisk George Vulgamott 19a. Informant's Name/Relationship (Type, Print) Alverta M. Vulgamott/Wife 3370 Clay Hill Road, Waynesboro, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/2012 Hagerstown, MD Rest Haven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical I or Attending Physician: The law requires that the death certificate be after death. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 No 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 🔀 Natural injury 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) **Hospital** (Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TW 3+1 istrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Crabet 11:58 2012 Leo Basil Williams 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Washington General Stewart Sharpsburg 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 1 □ M 2 □ F Months Days Hours Min. (Month Day Ye Country) "1937 74 215-34-2626 Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City. Town or Location 1 😾 Yes 2 🗌 No Washington Sharpsburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21782 USA 5021 General Stewart Ct 12. Was Decedent Ever in U.S. Armed Forces? 1 27 Yes 2 1 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Halls Transit 12 truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Alderton Basil J. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stewart Ct General Sharpsburg, MD <u> Janet Williams / wife</u> 20c. Location - City or Town, State 20a. Method of Disposition 20h Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Mem Gard 11/3/12 LaVale,MD 22. Name and Address of Facility 21. Signature of Foreral Service Licens Scarpelli Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a c - leisive that initiated events to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant

Physician/ Medical Examiner

and

signed by the attending physician

peen

this certificate has

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Funeral Director

Completed by

Be

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must ha matter and

Baltimore, Maryland 21215-0036

Examine as the burial-transit Physician/Medical use Ď be detached Be Completed by funeral director, ၉ Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

IF FEMALE:

25.

27.

only one) 29b. Signature and title of

31. Date filed (Month, Day, Year) NOV 0 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Yes 2 No 9 Unknown Unknown Yes 2 Other (specify) 1 Yes 2 Y										
Part II. Other significant conditions of			23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
	hypetlipidemia carcinoma of the bladdet 24a. Was autoperlo 1 yes										
25. Was case referred to medical			ck only one)								
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	lome 5 ₩ Residence 6	Other (Specify)							
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred						
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	1 28e Place of Injury . At he	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier 1 Certifying Phys	sician: To the best of my know	rledge, death occured	at the time, date and place, a	and due to the cause(s) an	d manner as stated.						

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

8258

29d. Date signed (Month, Day, Year)

Vovember

Registrar

State

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orthern

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29, 2012 Tina Lynnette Wood-Harris 2:04 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours (Month, Day, Year) 217-96-3585 32 Director 1 □ M 2 🛛 F 9/8/1980 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28a-f show any Injury or other traumatic event, the Madical Examiner must be in titled at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6602 Tall Woods Way 20735 U. S. A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔯 No Black, White, etc.
... African 1 Never Married 2 Married ۾ 1 ☐ Yes 2 ¥ No Specify: Completed 3 Divorced 4 Divorced Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MISSION Elementary/Secondary (0-12) College (1-4 or 5+) NASA-GSFC Business Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gary B. Jeffers Kathy A. Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philemon D. Harris/Husband 6602 Tall Woods Way, Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lakemont Memorial 11/03/2012 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. STURPS TH Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). certificete hes been signed by the ettending physician end lirector, page 2 should be detached for use es the burlal-transit To the Hospitel or Attending Physician: The lew requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Anatural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only on 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 10 State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 9:50 P M 2012 Willey E. October Devona Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anné Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Davs Hours 77 Director 219-32-7435 1 M 2 XF July 30,1935 Maryland Usual Residence of Deceder or than "natural", or items 23a or 28a-f ahow the Medical Expriner outst be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland Director Anne Arundel 1 🗆 Yes 2 😾 No MD Arnold 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral USA 21012 305 College Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highe grade completed) Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher permit. Pege 1 and 2 should be filed w Department of Health and Mentel Hygi Important: If item 27 is marked othe any injury or other treumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK မ Trema Edwin Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8640 Houlton Harbour Pasadena, MD 21122 Tammy Wright / Daughter Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 06 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD MD Veterans Cemetery 201 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Fune 1 Service Licensee Severna Park, MD 21146 495 Ritchie Hwy. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition EPSIS Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate rause. Enter I Ind. rlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the deeth certificate be executed 24 hours efter deeth. nding physician end use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death ed by the a Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by cete has been signer, r. page 2 should be a 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No certificete 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural injury 5 Pending To the Hospital or Attendin within 24 hours efter deeth.

To the Funerel Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

DICAL

29c. License numbe

#607

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State			-	-		f Health a				0011	00001
			Registrar 1. Decedent's Nam	a /First Middle 1 a	ct)		Cer	tificate o	f Death		2. Date of Dea	Reg. No	0. 2 11	2 38084
н	Physicia	_		Holechec							Month		2012 Year	3. Time of Death 10:10PM
	Medic Examin				e street and number)			4b, City, Town	n, or Location o	of Death	000	- 1	c. County of Dea	
-	- LAGIIIII	Ç.	Genes	is Heal	thCare-Tl	ne P	ines	Eas	ton				Talbo	
	Funeral		Social Security N	Number 6. S	Sex 7. Ag	e (In yrs. Ia	ast birthday)	If Under 1 Ye			8. Date of Birt		9. Bir	rthplace (State or Foreign
	Director		160-14-3 Usual Residence of	0049	I L W Z LAI	91	Yrs.				Sept. Da	16,1	1921 Ma	ryland
-1	show at	5	10a. State	10b. County		10c. City	y, Town or Lo	cation					•	10d. Inside City Limits
1	Maryla Ma	rect	Maryland	Talbot		Ea	aston							1 X Yes 2 ☐ No
27	a or 2 be no		10e. Street and Nur					10f. Zip Coo				10g. C	itizen of What Co	ountry?
6	h with	ΙčΙ	610 Dutch	ıman's La			,	216					USA	
	deat r iten iner r		11. Marital Status	177	12. Was Decedent I Armed Forces? 1 \(\sum \) Yes 2 \(\overline{X}\)	Ever in U.S	5. 13. \	Vas Decedent of Yes, specify C	of Hispanic Orig uban, Mexican,	gin? (Spec , Puerto F	ify Yes or No- lican, etc.)		14. Race - Ame Black, Whit	
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and	ntal H ed ot	To B	17. Father's Name ((First, Middle, Last) narles Ho					1		(First, Middle,		o Surname) N vratil	
ŽŢ,	ould b			ame/Relationship (7			10b Mailir	a Address (Str					or Town, State, Zi	in Code)
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Lillian Wanex Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	. //\	see 30	1.	22 Z	Name and Ad	dress of Facility	Home	, P. O.	Во	x 207 ket, MD	21621
				the disease, or com	nplications that caused one cause on each line	d the death							Ket, MD	Approximate
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enna it. vviigii		1- For State Certificate of Death		g. No.	33085						
Physici		Decedent's Name (First, Middle,Last)	2. Date of Death Month		3. Time of Death						
Medical Exami	ner	Velma R. Wright	October 30), 2012	1852 hrs						
		Velma R · Wright 4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital Clinton	n	4c. County of Death Prince George							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth	n(MM/DD/YYYY) 9. Birt							
Director		577-64-7694 1 M 2×F	08/31/	7,944 Foreig	in untry) VA						
		Usual Residence of Decedent									
ow any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No						
Maryland 28a-f show d at once.	ctor	MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour							
n, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medisal Examiner must be notified at once.	Director	568 Harry S. Truman Dr. 20774		AZU	,						
with t		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S			can Indian, Black,						
r death or itel	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	rican, etc.)	White, etc.	راء داء						
2 hours afte "natural", Examiner	Ş	3 Widowed 4 Divorced Iff Yes, Give Yeer 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	Specify: Bla 16b. Kind of Business/I							
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than injury or other traumatic event, the Medica	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or)		per. City or Town. State	Zip Code)						
MD id 2 shot slith and 1 is 1 i	٦	Maurice Wright / son 9169 Forest Breeze (t									
Te, Te, I and Healt fitem		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City or	Town, State						
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Baltimore, permit. Pages I at Department of Hee Important: If ite		21. Signature of Funeral Service Light Strickland Funeral Services									
Physician	. 103	232 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	Rd - Carr	ID Springs	MD 20748 Approximate Interval						
/Medical		failure. List only one cause on each line.	,	,	Between Onset and Death						
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	-	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of).									
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	ical	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)									
To T	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor							
		(0 (1 1 1 1 1 1 1 0.C.M.E.		October 31, 2012	2						
3.5m		30. Name and address of person who completed cause of death (Item 23a)									
		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore,	MD 21223								
St Regist	ate trar										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, L	ast)		timodito o. De	-	2. Date of Deat		3. Time of D	Death	
P	hysicia		Wai Lun Woo					Month 11	Day Year 2012		a _M	
	Medic Examin		Wai Lun Woo 4a. Facility Name (if not institution, gi	ve street and number)		4b. City, Town, or L	ocation of Death	- 11	4c. County of De			
<i>></i>			9508 Avenel Roa	đ		Silver S	Snring		Montgo	nerv		
Fi	uneral				s. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. B	irthplace (State or	Foreign	
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er de	or it	by F	1 Never Married 2 Married					Rican, etc.)	Black, Wh	ite, etc.		
rs aft	"natural", or items 23a or 28a-f show edical Examiner must be notified at		3 🛚 Widowed 4 🗌 Divorced	If Yes, Give Year or Dates.		1 🗌 Yes 2 🎦 No	Specify:		Specify: Ch	inese		
ئا-ئ	"natı	Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occupati kind of work done dur	ion rina most of workir	70	16b. Kind of Busines	s/Industry		
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land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene.	ed or	To B	17. Father's Name (First, Middle, Las.)		1	18. Mother's Name	,	Maiden Sumame)			
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene.	mark		Fong Kwan	(Time Drink)	1		Han Woo		01 - T - 01-t-	7/- (0 - /-)		
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Saltimore, permit. Page 1 and Department of Hea	Important: any injury o once.	1	21. Signature of Funeral Service Lige	11.0		1n Cemeter Name and Address			Brentwoo n Funeral		nc .	
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hysic Z	nis ce Il dire	유	1 🗆 Yes 2 🄀 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Other:	4 Nursing Ho	me 5 🔼 Resid	ence 6 Other (Spe	ecify)		
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DIVISION OF tal or Attending PI rs after death.	Direc in by	Certificate:	4 Homicide determine	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		City or Town	treet and Number or F n, State)	rurai Houte Numbe	τ,	
Spital ours	/ filled	edical	29a. Certifier 1 ✓ Certifying P	hysician: To the best of my kno	owledge, death	occurred at the time,	date and place, ar	nd due to the ca	use(s) and manner as	stated.	- 13	
UIVISION OT VITAI KECC To the Hospital or Attending Physician: The law within 24 hours after death.	le Fur	Med		miner: On the basis of examina urse Practitioner: To the best of							ner stated.	
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	TM		30. Name and address of person wh			Print)						
			Andrew Lee, MD	618 I Street			DC 200	01				
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. 2, Physician/ Wigfall 20°72 9:35 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 419 Larchmont Ave. Capitol Heights Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Days 577-56-4831 Hours **Director** Wash. DC 1 ☐ M 2💢 F 71 Yrs. 03-14-1941 Usual Residence of Decedent 28e-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Importent: If item 27 is marked other then "neture!", or items 23a or 28e-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any energy of the province of the Medical Examiner must be notified at any energy of the Medical Examiner must be notified at any energy of the Medical Examiner must be notified at any energy of the Medical Examiner must be not the Medical Examiner must b 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Capitol Heights MD PG 14 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 USA 425 Clovis Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3

Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Rich Ethel Sims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwayne Wigfall/Son 4310 Brookview Terr. Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 11-9-2012 Harmony Mem. Park Landover, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Ronald Taylor II FH ando 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🗷 No Month Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2-No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 📉 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) \(\text{Residence} \) မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA stor: After this y the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Direct I in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D completely filled in filled Medical 29a, Certifier 1 Q Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) d 5

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Registrar
DHMH 17 Rev 06-2011

State

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npleted cause of death (Item 23a) (Type, Print)

80

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sallie Dianne Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany Cumberland Western Maryland Reg Medical Center If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Hours Director 230-84-5827 1 🗆 M 2 🗓 F 59 Nov 17, 1952 Virginia Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director 1 Yes 2 No Maryland | Allegany Westernport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 25701 Shady Lane 21562 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 X Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Violet Virginia Howser Robert Lee Betson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18050 Norman Drive Fairplay, MD 21733 Virginia Betson / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 11/9/2012 Lovettsville, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 10 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year signed by the a ld be detached f 1 ☐ Yes ∠ g ☐ Unknown Unknown Part II. Other significant conditions of 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 🗌 Yes 1 Propatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No the Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier D0025406 cem M Wam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Lamm, MD, 12500 Willowbrook Road SouthEast, Cumberland, MD 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State MOA 0 8

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 A^{M} November 8:15 George Edward Wamsley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16505 Virginia Ave. Cottage 205 Williamsport Washington Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) . Social Security Number **Funeral** Min Hours 324-32-2427 Director 1 🗱 M 2 🗆 F 88 July 23, 1024 West Virginia Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at Director 1 Yes 2XXNo Maryland | Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 16505 Virginia Ave. 21795 Cottage 205 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "neathern" 14. Race - American Indian 1. Marital Status 12. Was Decedent Ever in U.S. th and Mental Hygiene. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner I 1 Never Married 2 Married 1XXYes 2 No If Yes, Give Year or Dates. WWII Completed by 3altimore, Maryland 21215-0036 1 Yes XXNo Specify: White 3XXVidowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Coal Industry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Benjamin Webster Wamsley Ruth Pritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17503 General Jackson Circle Sharpsburg, MD 21782 William Wamsley - Son injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Elkins, West Virginia Maplewood Cemetery 11-10-2012 4 Donation 5 Other (Spec 22. Name and Address of Facility Osborne Funeral Home, P.A. 21, Sign at re of Fundral Service 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Chronic Chelandine Ph_sician/ resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a nonsequence off Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Year Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Completed by Atralfbrillation, Congestive heart filme 1

Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv Yes 2 No 1 Yes 2 No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🗷 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 24 hours after death Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO050782 November 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Williamspart MP 21795 #3 Byrkith Drive Neal Patalinghing

DHMH 17 Rev 06-2011

Registrar

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

		1	For State Registrar	State of Mary		tificate of De	eath		Reg. No.		
	Physicia	n/	1. Decedent's Name (First, Middle, ROSEA77A	BENTRICE	h/A7	SON		2. Date of Dea Month	ath Bay 20	12 _{Year}	3. Time of Death
- many	Medic Examin	al .	4a. Facility Name (if not institution, g		INP	4b. City, Town, or Lo	ocation of Death	ος τ	4c. Cour	ity of Death	Caes (
	EXAIIIII	CI	Prince George's		ter	Chever1v			Prin	ce Geo	rge's
4	Funeral	4			yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h		lace (State or Foreign
100	Director	Ì	577-68-5498 Usual Residence of Decedent	1 □ M 2 🖾 F 64	Yrs.			March 2	.1948	Virg	inia
	and show	ē	10a. State 10b. County		c. City, Town or La	cation				1	0d. Inside City Limits
	Maryla 28a-f	Director	Maryland Prince	George's Se	eat Pleas	sant					1 X Yes 2 □ No
	a or 2		10e. Street and Number			10f. Zip Code			10g. Citizen o		
	th witl ms 23 must	Funeral	7207 Willow Hil	1 Drive	n110 113	20743 Was Decedent of Hisp	panic Origin? (Spe		United 14 B	State ace - Americ	
(0	er dea or ite niner	by Fu	11. Marital Status1 X Never Married 2 Marrie	Armed Forces?		If Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)		lack, White,	
036	rs afte Iral", Exar		3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1 🗌 Yes 2 🕱 No	Specify:		Spec	Blacl	k
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes		(Give	dent's Usual Occupati kind of work done dur	ion ring most of workii	ng	16b. Kind of	Business/Inc	dustry
121	thin 7 ene. than he Me	Som	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	O NOT use retired) cact Specia	aliet		Feder	al Gov	ernment
d 2	led wi Hygid other ent, t	Be	17. Father's Name (First, Middle, La	ast)	COHE		18. Mother's Name	e (First, Middle,			
lan	l be fil fental rrked tic ev	은	Oscar Watson, Si	r			Flortina	B. Fox			
lary	should and N is ma		19a. Informant's Name/Relationshi	ip (Type, Print)	19b. Maili	ng Address (Street an	d Number or Rura	Route Numbe	r, City or Town	, State, Zip (Code)
≥ (*)	ind 2 sealth sealth sim 27 her tr		Valeria Watson/		Capi	Karen Bou al Height			43 20c. Locatio	n - City or To	own State
lore	ge 1 ant of H		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State		matory or other place)		Date			
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funéral/Ser∳ice Li			n National 2. Name and Address					
Ba	permit Depar Impor any in		>Moorie 1	Sout	7.4 Wa	00 Georgianshington,	a Avenue District	, North	Weşt	20012	
			23a. Part 1. Enter the disease, or on shock, or heart failure. List or	complications that caused the	death. Do not en	er the mode of dying,	such as cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Pleysician/		Immediate Cause (Final disease or condition	FATAL	CARD	MAC A	RRHY7	MIA			Onset and Death
- American	Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):						
		er	Sequentially list conditions,	b. Due to for sele or o	пвидментом обр						
	Sansit ted	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	execu an an	Ĕ	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
092	icate be executed g physician and as the burial-transit	Physician/Medical	'	d							
687	ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy				23d.	Date of deliv	/ery
X	atten d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancyOther (specify)				Month	Day Year
Э. В	the de	hys	9 Unknown	9 Unknown							l of double
#2 Division of Vital Records, P.O. Box 68	requires that the death certifica been signed by the attending p should be detached for use as	by	Part II. Other significant conditio				en in Part I.	1			he cause of death? bably 4 Unknown
rds	equire een si nould	eted	.,46	ertension	1 . 05.40	6:400		24a. Was	1		opsy findings available
000	has b	Completed		LLOVIE LITURE	((304)	WO.0.00,		auto		prior to co	impletion of cause of
Ä	n: The ficate or, pag		25. Was case referred to medical			26 Plac	ce of Death (Chec		2 No	1 \(\text{Yes}	2 □ No
/ita	rsicial s certi direct	To Be	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	Other			idence 6 🗆 (Other (Specif	iy)
45	ig Phy ier this neral		27. Manner of Death 1 Natural 5 Pendin	28a. Date of injury	28b. Time			28d. Describe	how injury occ	curred	
#6	eath. or; Af the fu	ifica	2 Accident Investig	gation			res 2 □ No			, D.	- Deute Number
ivis	or Att	Certificate:	4 Homicide determi		At home, farm, si pecify)	reet, factory, office		City or To	wn, State)	mper or Hura	al Route Number,
۵	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying	Physician: To the best of my	knowledge, death	occurred at the time,	date and place, a	nd due to the o	cause(s) and m	nanner as sta	ited.
	he Ho in 24 i he Fui pletel	Medical	(Check 2 ☐ Medical E only one) 3 ☐ Certifying	xaminer: On the basis of exam Nurse Practitioner. To the be	ination and/or inve st of my knowledg	e, death occurred at th	e time, date and pl	t the time, date ace, and due to	the cause(s) ar	nd manner as	stated.
	古書		29b. Signature and title of certifier	12/	•	29c. License	number 1857		29d. Date sig		2012
			•	0	(har- 00-) T		1001			. 01	20, 2
			30. Name and address of person v	who completed cause of death	1 (item 23a) (Type,	HOSPI	TAL DI	2 CHG	NER	4	20785
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's	Signature						
	Registr		OCT 24	2012 /2	A Sol	well					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	yland /	-			and M	ental Hy	giene		
			Registrar	-41		Cer	tificate of L	<i>Death</i>			Reg. No.	20 + 2	38092
	Physicia	n/	Decedent's Name (First, Middle, La.							Date of De Month	Day	Year	3. Time of Death
. سو	Medic		<u>Theresa Swales</u> 4a. Facility Name (if not institution, give			-	4b. City, Town, or	Leastion		Novemb			16:30 p.m. ^M
	* Examin	er					Leonar					County of Deat St. Mar	
<i>y</i>	Funeral		23745 Hollywood 5. Social Security Number 6. S		n yrs. last bi	rthday)	If Under 1 Year			8. Date of Birt			thplace (State or Foreign
	Director		213-42-9685	□ M 2 🔀 F		Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	Co	untry)
	, M		Usual Residence of Decedent		91					06/06/	1921	Ma	ryland
	yland -f sh ed at	당	10a. State 10b. County	1	Oc. City, Tov								10d. Inside City Limits
	e Ma r 28a notifi	ie	Maryland St. Mar	y's	Leona	rdto							1 ☐ Yes 2 😾 No
	th th	la l					10f. Zip Code			[-	zen of What Co	
	ms 2	Funeral Director	23745 Hollywood 11. Marital Status	Road 12. Was Decedent Eve	r in LLC	12 1/	20650 Vas Decedent of H	ienanie Or	igin? (Sne	oify Voc or No		ted Sta	
က	or ite	by F	1 Never Married 2 Married	Armed Forces?		is. y	Yes, specify Cuba	in, Mexica	n, Puerto F	Rican, etc.)	'	Black, White	
<u>ම</u>	saft rai", Exar		3 ₩idowed 4 □ Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2X No	Specify	/ :		s	Specify: Bla	ick
5-0	"natu	plet	15. Decedent's E (Specify only highest gr		16		lent's Usual Occup		nt of workin			nd of Business/	
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2	d with lygier ther 1	0	12			Home	maker					wn Home	2
anc	ntal H ed of	To B	17. Father's Name (First, Middle, Last)							(First, Middle,			
$\tilde{\Xi}$	d Me d Me mark matic	Ì	Frank Swales 19a. Informant's Name/Relationship (7)	ina Drintl	T.,					ances M			
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ē,	l and f Hea item other		<u>Frances Frazier/I</u> 20a. Method of Disposition	Jaughter	20b. Place	of Dispo	sition (Name of			ate Oppe		cation - City or	MD 20772
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Donation 5 ☐ Other (Speci				natory or other plac	· .				·	·
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			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused th				•		-		Own, II	Approximate
	nysician/		Immediate Cause (Final disease or condition	110	hois	msu	-c Do	r. On	fice	,		- 1	Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (o:,a c	onsequence	of):	5 6-01	14700	4100				
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	sit a	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as a d	ønsequence	of):							
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0	icate be executed i physiclan and is the burial-transit	edical		l a									
1760	ficate g phy ss the	Je di		d									
8	onding use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		4b 2 [Ectopic pregnanc				2	3d. Date of de	livery
â	death	sick	in the past 12 months? 1 Yes 2 No	4 Pregnant at til			Other (specify)	;у				Month	Day Year
Division of Vital Records, P.O. Box 687	requires that the death certific been signed by the attending should be detached for use es	by Physician/M	g Unknown							1			
σ.	as tha igned be d	<u>آھ</u>	Part II. Other significant conditions of	ontributing to death but	not resulting	in the u	nderlying cause giv	en in Pan	(I.				the cause of death?
rg Sp	equir een s hould	etec								1 🗆			robably 4 🗌 Unknown
တ္တ	has b	Completed								24a. Was autor			topsy findings available completion of cause of
Œ I	sician: The law is certificate has tirector, page 2 s		25 Was soon referred to medical	***						1 🗆 Yes	2 No		s 2 🗆 No
ta	ysician: is certific director,	ωī	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Oth	\r.	ath (Check		` ,		Oanalla lade
<u> </u>	rthis eral d	<u>۾</u>	27. Manner of Death	1 ☐ Inpatient 28a. Date of injury		Outpatien Time of	t 3 L DOA 28c. Injun	_ 4 L N		ne 5 ∐ Resid 8d. Describe h		Other (Spec	in la unital
ב	ath. ath. r: Afte	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Y	'ear)	injury	work			04. 200000	.o.vgo.y	00001100	Perme
isi.	• Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		- At home, f	arm, stre	et, factory, office		2			Number or Ru	ral Route Number,
	pital or Attending Phours after death. eral Director: After th filled in by the funeral					_				City or Tow			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use es	Medical	(Check Z L Medical Exam	sician: To the best of my iner: On the basis of exan	nination and	or invest	igation, in my opinic	n, death o	occurred at	the time, date a	ind place, a	and due to the	cause(s) and manner stated.
	To the Hosp within 24 ho To the Fune completely f	ž	only one) 3	se Practitioner: To the b	est of my kn	owledge,	death occurred at t	he time, da	ate and plac	e, and due to t	he cause(s	s) and manner a	s stated.
	F≥F8			ann1			290. License	11)	57	01	Zgu. Date	signed (Month	1. 2012
J	•	ŀ	30. Name and address of person who	ompleted cause of deat	h (Item 23a)	(Type P	rint)	100	01)		-05	- 0010
4	eme		Jennifer Schmidt	. D.O. 409	,		nts Lane	Sur	te 20)5. Iaa	mard	town h	fD 20650
	Stat	е	31. Date filed (Month, Day, Year) NOV 0 8 2	32. Registrar's	Signatur			لللات		1.PEU	щаш	<u> </u>	ur
	Registra	ır	NUVUOZ	U12 Chara	p.	190	aks						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #19a Per FH Gp34 12/10/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ :15 AM 201 Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner MONTGOMERY BREW OCKVIL .6 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Social Security Numbe Funera (Month, Day, Year) Days Country) Months Hours Min. 1 M 2 X F Maryland 96 577-58-2374 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10c. City, Town or Location the Medical Examiner must be notified at rector 1X☐ Yes 2 ☐ No MD Montgomery **Bethesda** ۵ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a Funera United States 20B14 4925 Battery Lane hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or 9 Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify. White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. National Institutes Elementary/Seconday (0-12) College (1-4 or 5+) Of Health Secretary 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumathe avents 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Sylvia Symonds Herman Rombro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan Joanne Cole - Daughter 11912 Stonewood Lane, Rockville, Maryland 20852 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gardens 11-27-2012 Falls Church, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Edward Sagel 4 1170 Rockville Pike, Rockville, Maryland 20B52 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR Physician/ ACCIDENT ONE WEEK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner YEARS FIBRULLATI TRIAL Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and burial-trar Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use res, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown After this certificate has been signed by the atte funeral director, page 2 should be detached for it Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CHRONIC OBSTRUCTIVE PULMONARY DITEASE 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown The law requires Completed 24b. Were autopsy findings & 'ailable prior to completion of cause of death? CONGESTIVE HEART FAILURE 24a. Was an autopsy performed; 2 No 1 🗌 Yes Yes To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation ☐ Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 社人

M. D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121

MONTROSE

32. Registrar's Signature

00072782

ROCKVILLE, MD 20852

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZELDA ANSHEL 10:27 AM ovember Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A hmorr If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours (Month, Day, Year) 09/30/1920 Director 219-03-6918 1 □ M 2 🗶 F 92 MD Yrs Usual Residence of Deced 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at Director N/A 1 X Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7218 PARK HEIGHTS AVENUE 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WHITE 3XXWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 Is marked other than ' ury or other traumatic event, me Me Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT **EDUCATION** Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) မ GOLDSMITH JOSEPH. BESSIE MALL OW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN KAMPLER/DAUGHTER 3407 GAITHER ROAD, BALTIMORE, MD 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: If any injury or once, 11/27/2012 /27/2012 ROSEDALE, MD SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a a consequence of) Examiner TYAC Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burlal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital comments within 24 hours after death.

To the Funeral Director: After this certificate has been signer completely filled in by the funeral director, page 2 should be to 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Breast autopsy performed? Yes 2 No 1 ☐ Yes 2 💆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 1950 PM 1 🗌 Yes 21/2012 2 No Fal Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HSSISTEA LIVING FAC 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)
18 Park Hci Faculity Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner—To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

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LINDION

Baltimore MD, 21215

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Ste

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Auren H. Smith 2435 W. Belvedere Ave

32. Registrar's Signatur

Smith

auren

31. Date filed (Month, Day, Year)
NOV 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2012 Month Physician/ 7:30 P Franklin D. Bonner Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 225 Frock Dr., Apt. 340 Westminster Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours Director 232-60-5748 Usual Residence of Dec 1 JxM 2 🗆 F 74 8/23/1938 WV or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits at filed within 72 hours after death with the Maryland Director notified MD 1 Yes 2 No Carroll Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe Funeral items 23a must t 225 Frock Dr., Apt. 21157 340 . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ori þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. white Specify: "natural", 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Home Improvement other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Inez Evans Ola Bonner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8114 Casey Ct., Elkridge MD 21075 Emily Beck--daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State injury or 11/7/2012 Westminster, MD 4 Donation 5 Other (Specify) Central MD Crem. any inj once, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral & Cremation Thomas D. Fletcher III per DVR 254 E Main St., Westminster MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events Hypertension Examiner Due to (or as a consequence of): and Due to (or as a consequence of): resulting in death) Last iding physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 X No this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5X Residence 6 \square Other (Specify) 1 🗌 Yes 2x No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d, Describe how injury occurred After 5 Pending injury 1X Natural Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 within 24 hours after death. To the Funeral Director: A

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month. Day, Year)

D62786

Business Center Dr., Reisterstown MD 21136

completed cause of death (Item 23a) (Type, Print)

Vento MD Thomas J.

31. Date filed (Month Nov 2 8 2012

30. Name and address of person who

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38096 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ NOVEMBER 2012 JAN E. BUTER 4:45 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL HEALTH AND REHABILITATION FOREST HILL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year, Hours Min Director 215-22-2867 1 XM 2 □ F 87 06/09/1925 Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location notified at Director 1 Yes 2 X No MD Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 0 10e. Street and Numbe must be r Funeral 217 B Crocker Drive 21014 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian "natural", or iten Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced WW II Completed Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the 12 Supervisor of Construction Construction Industry event. Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jan Buter Katherine Lampe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 B Crocker Drive - Bel Air, Madeline E. Buter (wife) Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/20/2012 Baltimore, Maryland Parkwood Cemetery 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses 11750 Belair Road - Kingsville, Maryalnd 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician JUNDIOME mylecoysplostic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) iding physician Physician/Medical certificate be P.O. Box 68760 the use as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Hospital or Attending Physician: The law requires that the death 24 hours after death.

Funeral Director: After this certificate has been signed by the atte Other (specify) Pregnant at time of death signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ (OPD) 1 Yes Records, 2 No 3 Probably 4 Qunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an CAD page 2 autopsy performed DEMENTIA 1 Yes 2 No Yes 2 Division of Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral c 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 5 Pending injury Natural 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

Dals

NOV 2 8 2012

DR.DAVID DUNN 31. Date filed (Month, Day, Yea

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W.

MACPHIL ROAD -

32. Registrar's Signatu

5) 32299

BEL AIR, MARYLAND 21014

No sember 13 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BEEMAN NOVERGERE Physician/ 8:55 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSP11741 MHDSTAR HARBOR BALTITIORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours 218 36 9245 1 **X** M 2 □ F Director Maryland 71 01/29/1941 show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County notified at Director 1 Tyes 2 No 28a-f Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö must be n Funeral 21061 U.S.A. 411 Burwood Avenue items 2 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc ģ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 10 Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ada Shock Arthur Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Salley / Daughter 411 Burwood Avenue Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/27/2012 Baltimore, Maryland Mt. Carmel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or co shock, or heart failure. List on lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death Immediate Cause (Final ST elevenous MUDCOVAICE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 the use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u in the past 12 months? Month Other (specify) Pregnant at time of death the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ binknown Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 Fibrillanon Yes 2 L 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Yes 2 ☐ No Other: 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) brember 21, 2012 WES OO

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year

S. Hanover St.

Baltimere, Maryland 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1230 PM bastian 2612 bagallo November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Yrs. 93 May 4, 1919 215-09-5302 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 X No Director Baltimore Co. must be notified MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö 23a Funeral 21224 United States 7615 Carson Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene.

other than "natural", or Ite 1 Never Married 2 X Married XXYes If Yes, Gir 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government 2 Years Schedule Analyst 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot should be Anna Mandella Frank Barbagallo ည Wife 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 Mrs. Elinor R. Barbagallo Baltimore, Maryland 21224 7615 Carson Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If iter any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem12/3/2012
Reed | 22 Name and Address of Facility Baltimore, Maryland 21. Signature of Funeral Service Licensee Gregory E. Duda-Ruck Funeral Home of Dundalk, Inc. tregor 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Firm **Physician** ardiac arres disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** ardiomyopathi Sequentially list conditions, that yell additions to the cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death ed by the at detached for 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No 21X No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day or Attending 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No death. 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 2

State Registrar Michelle

Baltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital Records,

Division

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

29c. License number

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

november 26,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6.21 NOVEMBER 23 2012 BLAIR SUSAN 0. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days **Funeral** 1 □ M 2 😾 F 212-78-5907 19,1970 Maryland Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant; If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10b. County er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director Baltimore City MD N/A 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21224 United States 452 North Robinson Street Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White <u>م</u> 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hair Salon Cosmetology 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Manuel Panzarotto Benita Kramer ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 452 North Robinson Street Mr. Bryan M. Blair (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial XXCremation 3 ☐ Removal from State Hilltop Service Corp. 11/28/2012 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee Michael Neiser 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 100 wh Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** SOFT TISSUE INFECTION NECROTIZING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 2 No detached Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 🗌 No Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ၉ this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director; A 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Continuous of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 hor To the Funel completely fi (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 23, 2012 20059114

DHMH 17 Rev 1/2001

State Registrar 4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATHANIEL MEGUAY, JP., M.)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Norma L. **Blische** 8:44 P Medical 201 Nov 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Heritage Nursing Home Dundalk Baltimore Co. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) Country) 216-16-1359 Director 1 ☐ M 2 💢 F 88 Yrs. ,1924 Nov Maryland ms 23a or 28a-f shormust be notified at 10a State 10c. City, Town or Location 10h Count Director 10d. Inside City Limits MD 1 ☐ Yes 2 🙀 No Baltimore Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 829 S. 50th Street 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Widowed 4 ☐ Divorced If Yes, Give Completed Specify White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Cinda Bensen George Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 6820 Martin Avenue Dundalk, Maryland 21222 David Blische (Son) altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite eny injury or ot once, Date 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Park 11/27/2012 Elkridge, Maryland Signature of Funeral Service Licensee Michael Neiser 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death HEROSCLEROTIC Physician/ CARDIOVASCULAR disease or condition resulting in death) Medical Examiner ENTION Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying THRITIS Cause (Disease or injury attending physicien and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical NXIE Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 1 Yes 2 🗷 No to or Attending Physician: The after death.

In Exercise After this certificated in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 12 No မ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune within 2 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) Marked-Plan

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mamie Elizabeth Brown 2012 11:10p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2412 Shirley Ave. Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months Days Hours Country) 214-30-4238 Director 1 □ M 2 🗶 F MD 78 04/23/1934 permit. Page 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show eny Injury or other treumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director N/AMD 1 X Yes 2 No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 2412 Shirley Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) 9th College (1-4 or 5+) Pall Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hannah Battle Harry Battle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2412 Shirley Ave. Baltimore, MD 21217 Joseph E. Brown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11/29/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Arbutus 21. Si provine of Funeral Service Libersee ²² Name and Address of Facility OSEPN H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave. 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the bunal-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death s been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes ြုင 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No within 24 hours after death.

To the Funerel Director: Air completely filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funerel D 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 6:55 150 201 give street and number, 4c. County of Death Maryland altimore N/A 8. Date of Birth (Month, Day, Year) If Under 1 If Under 24 Hrs. Min 1 M 2X F 66 Yrs. 4/12/1946 10h County 10c. City, Town or Location Baltimore Gwynn Oak

For State Registra Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical Facility Name (if not institution, Examiner Birthplace (State or Foreign Country) **Funeral** 042 - 38 - 6462Director New Jersey permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits Director MD 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2121 Windsor Garden Lane #421B 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Agent Insurance Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jessie Bell Grace Prince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5402 Grindon Ave. Baltimore, MD 21214 Luan Livingston (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State bate cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 28/12 On-Site Crematory Baltimore, MD 4 Donation 5 Other (Specify) Signatu 22josepheni Fabrown, Jr 2140 N. Fulton Ave. Jr. Funeral Home PA Balto., MD 21217 Balto., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hours monar disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month 1 Yes 2 No 9 Unknown Por Year Month Day 5 Other (specify) Pregnant at time of death bed ! the s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 has page 2 certificate funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 2 No 1 Npatient 2 ER/Outpatient 3 DOA After this Certificate: Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 24 hours after death filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one 29d. Date signed (Month, Day, Year) 29b. Signature and title. 29c. License number 2012 vame and addre of person who completed cause of death (Item 23a) (Type, Prin 22 balabai Date filed (Month, Day, Year)

State Registrar

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and show	5	MD NA	Ва	ltimore					1 X Yes 2 No
Maryla 28a-f d ato	Director	10e. Street and Number	·	10f.	Zip Code		100	g. Citizen of What Co	ountry?
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Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Haulth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Denise Bailey-S	ister	2509 K	eyworth	Ave,	Balti	more, Mo	21215
re, land f. Heal		20a. Method of Disposition 1 Burial 2 X Cremation 3		Place of Disposition (crematory or other place		΄, Γ	ate	20c. Location - City	or Town, State
MO Pages pent of profit.		4 Donation 5 Other Specify:	Removal from State	Metro		11/2	26/201	2 Baltin	ore, Md
Salti eparti nport ijury		21. Signature of Funeral Service License	*/	22. Name	and Address of Fa	cility est			
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Box 68760 e death certificate be the attending physic ed for use as the bu	sicia	1 Yes 2 No 9 Unknown	4 Pregnant at time of de	eath 5 Other (Specify)			Î	
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tal Reco cian: The law certificate has		25. Was case referred to medical		-	26.Place of De	ath (Check onl			163 2 110
Vita hysicia this ce I direc	o Be	examiner? 1 Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3	DOA Other	4 Nursing I	Home 5 R	tesidence 6 🗸 Oti	ner: Scene
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Foureral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	T:L	27. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at V		3d. Describe ho	ow injury occurred	
Sior Attend death cetor:	catic	2 Accident Pending Investigation			1 Yes 2				
Divi	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, fac	ctory, office building	g, etc.	or Town, Sta		Rural Route Number, City
Hospit 4 hour Funer:		4 Homicide 29a. Certifier 1 Certifying Physician	: To the best of my knowled	de death occurred a	t the time, date and	d place, and du	ie to the cause	(s) and manner as s	tated.
To the within 2 To the Complet	Medical	one) 2 Medical Examiner: C	on the basis of examination a						
E E S	Me	29b. Signature and title of certifier	Name of the state		29c. License num	ber		29d. Date signed (#	
I V		Pamele Southall	mo		O.C.M.E.			November 17,	2012
OW		30 Name and address of person who co	mpleted cause of death (Item Assistant Medical Exa		Baltimore Str	oot Ration	ore MD 21	223	
	tate				Daminote Str				
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12-08/8/ Minda Ruth Brewste	otate of Maryland / Departmen	it of Health and Mental H		012 38104				
	Registrar	e of Death	Reg. No.	0 1 2				
Physician/ Medical Examiner			2. Date of Death Month Day November 18, 2012	Year 2327 hrs				
	4a. Facility Name (if not institution, give street and number) 204 Broadwalk Place	4b. City, Town, or Location of Death Gaithersburg		inty of Death gomery				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 156-40-0050 1_M 2 1 60	y) If Under 1 Year If Under 24Hrs Months Days Hours Min		YYY) 9. Birthplace (State or Foreign Country) NJ				
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show. Injury or other traumatic event, the Medical Examiner must be notified at once, To Be Completed by Funeral Director	or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify:	Spec	Vhite, etc. White cify:				
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation (Give kind of ving most of working life. DO NOT use reti	red)	of Business/Industry				
15-0036 Tiled within 72 Hygiene. 4 other than the Medical	4 Admi	nistrative Assista	_	rofit				
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MD 21 nd 2 should alth and Me im 27 is ma "aumatic cv	Samuel Brewster/Son 21	lailing Address (Street and Number or F 512 Manor View Cir	cle Germantow	n, MD 20876				
Baltimore, permit. Pages I as Department of He. Important: If ite	1 Burial 2 X Cremation 3 Removal from State crematory	o. o.i.o. place,	V. 21,	ion-City or Town, State				
Balti permit. Departit Importit injury o	21. Signature of Funeral Service Licensee REDECCO HECKLY MON	22. Name and Address of Facility app 933 Gist Ave. Silv	er Spring, MD	20910				
Physician /Medical Examiner	23a Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line. Mixed drug Into Immediate Cause (Final disease a. Hydrocodone, Oxycodone)	oxication (Morphine	e, Doxepin,	r heart Approximate Interval Between Onset and Death				
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Lusit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
5	events resulting in death) Last Due to (or as a consequence of): d. X UNPENDED AMENDED 23a,27,28a-f	12 cm						
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Division of Vital Records, P.O. Box 68760, To the Bospital or Atteoding Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Fuoeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial edical Certification: To Be Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown	Fetal death 3 Ectopic pregna Other (Specify)		e of delivery th Day Year				
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Records, The law require, ffcate has been sign, page 2 should be			24a. Was an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
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FVit Physici or this c	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	itient 3 DOA Other Nursin	g Home 5 Residence	6 🗸 Other: Scene				
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Division o Hospital or Atteoding 24 hours after death. Fuoeral Director. And teldy filled in by the func- ial Certification:	3 X Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, (Specify) Hotel/Motel	street, factory, office building, etc.	28f. Location (Street end Nu	Imber or Rural Route Number, City Broadwalk P1.				
Division of To the Hospital or Atteoding Pl within 24 hours after death. To the Fuorral Director. After completely filled in by the funeral	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investant manner stated.	occurred at the time, date and place, and	due to the cause(s) and mar	nner as stated.				
	29b Signature and title of certifier Part Part (1, M)	29c. License number O.C.M.E.		signed (Month, Day, Year) Der 19, 2012				
Hours.	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	900 W. Baltimore Street, Baltin	more, MD 21223					
State Registrar	31. Date filed (Month, Day, Year) NOV 2 8 2012 August 4	bare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 10:30 Marie Bartkovich Hovember Beatrice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Baltimore TOWSON Joseph Medical enter Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 213-18-1016 91 Director 1 🗆 M 2 🖾 F Maryland May 23, 1921 Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Importent: If item 27 is merked other then "netural", or items 23a or 28a-f show emphylury or other treumatic event, the Medical Expriner mast be notified at once. 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 Yes 2XXNo Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21286 927 Beaverbank Circle BEATRI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 Yes 2 XNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Catherine Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 927 Beaverbank Cir., Towson, Janis Bechtel-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/1/12 Timonium, MD Dulaney Valley 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Y Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cident Physician/ erebrovascul ase or condition Medical resulting in death) Examiner al 1 week Fibrill Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my onlines, death account of the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 1 only one) 29d. Date signed (Month, Day, Ye 29c. License number 29b. Signat use of death (Item 23a) (Type, Print) 7601 Osler Drive Towson Maryland 21204 dar Utzschnei 31. Date filed (Month, Day, Year) NOV 28

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Brown 2012 Physician/ 3:35 PM BROOKS HELEN VIVAN -Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner DRIVE WASHINGTON 785 MONET HAGGRSTOWN 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 212-58-9884 Director 1 M 2 F 1952 100 MD. QT. 11 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State items 23a or 28a-f shoner items 23a or 28a-f shoner items for a continued at MD WASHINGTON Yes 2 No HAGORSTOWN 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 785 MONET AZV 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: BLACK "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Northeastern marked other than matic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) ADMIN. UNIUGESITY traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filled.
Department of Health and Mental Hyllmportant: If item 27 is many injury or other. 17 Father's Name (First, Middle, Last) HOPE WEST SHARPE BROOKS WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 785 MONET Dr. HAGGESTOWN MD. 21740 DAWN THARPS 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State NOV. 28,2012 Smous Boro, MD. SMATHEBURG CREM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLUNS FUNCTAL Home 21. Signature of Funeral Service Licensee Suy Z. 110 WEST SOUTH ST FREDERICK MO complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, o shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t signed by the attending Id be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 4 Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No After this certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to the funeral director, to the funeral director, the funeral director is the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural . ₊atural ☐ Accident ☐ Su 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2012 Do068995 dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 NOV 2 8 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Physician/ DWY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD HUMMINGBIRD ASSISTED LIVING ABERDEEN 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Director 173-03-7437 1 XM 2 - F 06/12/1919 WEST VIRGINIA 93 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other then "nature!", or items 23a or 28e-f shoinny injury or other treumetic event, the Me Xoal Evaniner must be notified at 10a, State Director 1 Yes 2 No MD HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 502 PLUMTREE ROAD 21015 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 944-45 1 ☐ Yes 2 TNo Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MANUFACTURING MACHINIST Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ BROWN MINNIE LEE HAMPTON BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PLUMTREE ROAD, BEL AIR, MARYLAND 21015 LINDA ATWELL/ FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 K Cremation 3 Removal from State BAYVIEW CREMATORY 11/21/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Service Licenses & ZETLER INC. FUNERAL HOME CONKLING STREET, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Seath Immediate Cause (Final Physician pay disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, eaong to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificete be executed cate has been signed by the ettending physician end page 2 should be detached for use as the buriel-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 1 Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours at er death, Funerei Director; After this certificate has autopsy performe 2 No 1 Yes 2 N 1 🗌 Yes 25. Was case referred to edical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural 2 🗌 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of

State Registrar 30. Name and address of person when the state of the stat 030 18 31. Date filed (Month, Day, Year, 32. Registrar's Signature

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use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11cm 29d per doc 2934 12-4-12 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year NOVEMBER 26 2012 SELMA 01:05PM **BLUM** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUNRISE OF FREDERICK FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 218-32-0343 1 □ M 2 🖾 F Yrs 11/13/1916 96 MD permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If itsm 27 is merked other then "neturel", or items 23s or 28s-f show empirity or other traumetic event, the Medical Examinat be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD FREDERICK FREDERICK 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 990 WATERFORD DRIVE 21702 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If You Give Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) RETAIL GIFTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL BERNSTEIN **GERTRUDE BROTMAN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAYLE FREYMAN/DAUGHTER 312 CHERRY CHAPEL ROAD, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANSHE EMUNAH
AITZ CHAIM 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/27/2012 BALTIMORE, MD 21. Signature of Funeral Service Lio 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CHRONIC RENAL DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that is instead account.) Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transif Hospitel or Attending Physicien: The law requires that the death certificata be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC ANEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available DEGENERATIVE JOINT DISEASE autopsy performed?/ 1 Yes 2 No prior to completion of cause of death? certificate 1 Yes 2 No erei Director: Aftar this certific filiad in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 8 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 🗹 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-26-12 Name and address of person who completed cause of death (Item 23a) (Type, Print) Monte Ir. Jued W. Haque 00 laire 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0253A1 20 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner so of Har Hazo If Under 24 Hrs. ial Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. Vast birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Jan 13, 1937 1 M 2 F Min 214-34-7663 75 MD Director 28a-f show 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral 21230 U.S.A. 2709 Maisel Street items death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Clothing Company** Seamstress 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 Edna Hammond David Hammond Page 1 and 2 should be other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 2709 Maisel Street, Baltimore, MD 21230 Deborah Means 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Nov 29, 2012 Baltimore, Maryland **Arbutus Memorial Park** 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 505 < disease or condition # Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for sella consequence of Cause (Disease or injury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 Pregnant at time of death Month Day Year ed by the ar No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) P 1 Yes 1 Inpatient 2 FR/Outpatient 3 I DOA Certificate: 27. Manner of De Th 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 003306 . Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Year)

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31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ 06:45 PM 2012 BRILL FLORENCE ANN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/ABALTIMORE SINAI HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birtholace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) Months Days Director 214-14-0655 1 □ M 2 🗓 F 01/23/1920 MD 92 Usual Residence of Decedent or then "natural", or items 23e or 28e-f show the Medical Examinar must be notified at 10d, Inside City Limits 10a, State 10c. City, Town or Location with the Maryland Director 1 😾 Yes 2 □ No MD N/A BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral USA 21209 6115 BERKELEY AVENUE, APT. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. "natural", or ş 1 Never Married 2 Married 21215-0036 within 72 hours, after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other then " Elementary/Secondary (0-12) College (1-4 or 5+) GROCERY SALESPERSON permit. Page 1 and 2 should be filed wit. Depertment of Health and Mental Hygier Important: If Item 27 is marked other t. any injury or other traumatic event, the sonce. Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ORENTZELL BENJAMIN GLASSBAND IDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6115 BERKELEY AVENUE, APT. A-1, BALTIMORE, MD 21209 STEPHANIE YOFFEE/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/25/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) FORBAND CEMETERY 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licenses Cel 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE NEARCTION Physician/ MIDCALDIAC disease or condition Medical resulting in death) Due to (or as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): buriel-trensit or Attending Physician: The law requires that the deeth certificete be executed To the Hospital or Attending Physician: The law requires that the deeth certificete be executi within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funerel director, page 2 should be detached for use es the buriel-tren that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 o Other: |2 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA Home, 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inventication in proceedings. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 77 1039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.AVCOBUTS SMITH AVE B1427 M 1835 1 Au 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 8 2012 Registrar

2

107

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. AMEND 11EM#20b, perFH, G933, 11/28/2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** rgare + November 24 2015 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 DM 2 J13-60-740 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director imore MI) 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Black 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) Be James White Sr. 19a. Informant's Name/Relationship (Type. Print) 94/4 more MU 21206 Gean Larry rawtura 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition UNK 12-1-2012 Baltimore MD

22. Name and Address of Facility a ushin C. Greene Funeral Services
4905 York Ruad Baltimore, MD 21212 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity 21. Signature Hun ral Service Licensee 8 10155 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiad shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Gastrointestinal Bleed **Physician** Massive /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) s certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Box 68760, Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4 Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 → nknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 10 1 🗌 Yes To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ၉ filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 24,2012 address of pareon, who completed cause of death (Item 23a) (Type, Print) 30. Name and Bright 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar NOV 2 7 2012

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Clark 10:4541 2012 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner N/A Slas mose If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours 216 14 3209 Director 1 🗆 M 2 🗓 F 91 Maryland 07/16/1921 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health end Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-f show eny injury or other treumetic event, the Modical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21225 U.S.A. 223 Grove Park Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Seibel Maurice E. Keegan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rod Clark / Son 7916 Putney Terrace Glen Burnie, Maryland 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗀 Removal from State Glen Haven Mem. Park 12/01/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Pulminavy Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2. No 1 ☐ Yes 2-10 N Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-12 No ျ 1, Propatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical LE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ante Chandelwasmy November 27, 2012 DO05'2490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUR MANOVERST BAILING MD 21235 Khandelwal MD (300),

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 8 2012

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Corbett 3:20p. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Summitt Park Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month. Day, Year) Hours Country) 050-52-3999 Director 1 □ M 2 🛣 F 82 02 13 30 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 XYes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 3810 Derby Manor Drive U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 X No Specify: Black If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Disabled Disabled æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Corbett Estelle Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore. 21215 Lena Carter-Cousin Derby Manor Drive, 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State cemetery, crematory or other place) tX□ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 12/1/2012 Woodlawn, Md Signature of uneral Service License March and Address of Facility 4300 Wabash Ave, Baltimore, Md 21215 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. Inter the disease, or complications that cau or heart failure. List only one cause on each shock Onset and Death Immediate Cause (Final DEMENTIA Physician UNENOWN disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RETAPOATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 🕊 No 1 Yes 2 No 24 hours after death.

Funeral Director: After this certifica letely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) |은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0000586 26 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERRY FA BALTIMORE: HAMMONDS filed (Month, Day, Year) State 2 8 2012 NOV

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Grace ure Date of Bill. (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral 7. Age (In yrs. last birthday) Days Hours Min New Jersey Director 1 M 2 □ F 73 213-34-8736 1939 Yrs item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Important of Health and Mental Hygiene.
Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have also any injury or other traumatic event, the Medical Examinar must have also 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Havre De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 Market Street 21078 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ ♣ ♥ o If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Tug Boat Captain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Cifarelli, Sr. Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard Thomas Cifarelli, Jr. /Son 632 Colora Road Colora, MD 21917 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2012 Chesapeake Crematory 21. Signature of Funeral Service Licensee 401443 22. Name and Address of Facility Funeral Alternatives Pastures Drive Towson Maryland 21286 23a. Part 1. Erter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opert and Death shock, or heart failure. List only one cause Immediate Cause (Final Physic and 0 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be exe Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 No Pregnant at time of death signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has 2 No 1 Tes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 🗌 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (I 93 31. Date filed (Month, Day, 2. Registrar State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 4a, per phy, g933 11-28-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 18 Physician/ Cowley 2012 1:26 A M Patsy Jean Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3405 Buffalo Road New Windsor Frederick If Under 1 Year If Under 24 Hrs Months Days Hours Min 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 589-58-4885 1 🗆 M 2 🕱 F Yrs 30 Jul. 15, 1982 Florida Usual Residence of Decedent show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified a MD Frederick 1 Tes 2 X No New Windsor 10e. Street and Number 10g. Citizen of What Country? ö ms 23a or must be i Funeral 3405 Buffalo Rd., Apt B 21776 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 🗌 Widowed 4 🗌 Divorced White Completed Year or Dates marked other than "natur matic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. item 27 is marked other than " other traumatic event, the Mea Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Michael Miner Judy Holder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 Buffalo Rd., David E. Cowley - husband New Windsor, MD 21776 other **Baltimore**, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of P Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 11/20/2012 Sykesville, MD 21. Sign tyle of F ral Service Vicensee Landus 22, Name and Address of Facility Hartzler Funeral Home P.O. Box 249, New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death seconds Immediate Cause (Final Physician/ Asystole disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypoxia minutes Sequentially list conditions, Examine Due to (or as a son sequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Encephalopathy days pue the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Leptomeningeal Carcinomatosis weeks Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Metastatic Rectal Squamous Cell Carcinoma 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No I ☐ Yes 2 🕱 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Hospital or Attending Pl 24 hours after death. Funeral Director: After the 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D67742 11/20/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 21702 32. Registrar's Signature 46B Thomas Johnson Dr. Yun Oh NOV 2 8 2012 Registrar

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Page 1			1 X Burial 2 4 ☐ Donation		3 Removal fro	m State			matory or oth			11/2	9/2012			-		
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pital C	within 24 hours after death. To the Funeral Director: After completed filled in by the funer		29a. Certifier 1	Contific	Dhygisian Ta *	host -f	mu lene!		me	ho time -	data		ויייטא אסטיו	ie,	Ma	212	34	- 73
To the Hospital	24 hc	ledical	(Check 2 only one) 3	Medical E	Physician: To the Examiner: On the b Nurse Practione	asis of e	xamination	and/or inves	tigation, in m	ne ume, ny opinion	n, death or	ccurred at	the time, date a	and place	e, and du	ue to the c	ause(s) and manne	er stated.
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Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WOODLAWN CEMETERY 12-5-2012 BALTIMORE, MARYLAND D. HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Sign 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIA C disease or condition 15 MINS Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or se a consequence or) cause. Enter Underlying Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending I hours after death.
uneral Director: Afted filled in by the fur 1 🗌 Yes 2 🗀 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be

Division of Vital Records,

State Registrar

within 24 hours a

To the Funeral C

completed filled i

Medical

29a. Certifier

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, weath cooling at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

21207

City or Town, State)

BALTIMORE

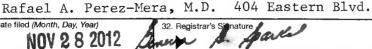
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dembeck 201^{Yea} Raymond Leo 19, 11:30 AM Nov. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9224 Todd Avenue Baltimore Fort Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days (Month. Day, Year) Country) 215-30-7242 Director 1 XM 2 | F 78 Yrs May 19,1934 Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b Count 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Fort Howard MD Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9224 Todd Avenue United States 21052 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Completed by Black, White, etc. 1 Never Married 2 X Married 1X Yes 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Divorced 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Baltimore Sun Papers Printer Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည Pauline Stwietskowski Leo G. Dembeck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Geraldine C. Dembeck 9224 Todd Avenue Fort Howard, Maryland 21052 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of F Important: If ite any injury or otl once. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hillton Service Corp. 11/23/2012 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Gregory Reed 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or how fallows as to only one cause on each line. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Congestive Cardiomyopathy
Due to (or as a consequence of): Years Medical Examiner Coronary Heart disease with old myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Chronic Kidney Disease nding physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 been signed by the attending I should be detached for use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Marked left ventricular dysfunction Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy certificate rmeg? 2 ⊠No 1 ☐ Yes 2 ☐ No ☐ Yes by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🏻 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation **Director:** 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Division of Vital 24 hours To the within 2

State Registrar

31. Date filed (Month, Day, Year) NOV 2 8 2012

29b. Signature and title of pertition



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHMH 17 Rev 06-2011

29c. License number

D10613

29d. Date signed (Month, Day, Year) November 20, 2012

21221

Essex, Maryland

Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

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Physicia edical Exami	an/	Decedent's Name (First, Middle,Last)	oria Lynn De <i>l</i>	Angelo		2. Date of Dea		3. Time of Death 2211 hrs			
Culcai Exami		4a. Facility Name (if not institution, give str	<u>·</u>		ty, Town, or Location		4c. County of Death				
		Curtis Creek Bridge on I-695	1		Itimore	lo p					
Funeral Director		5. Social Security Number 218-31-6052 6. Sex 1 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Days Hours Min. March 14,1991 9. For									
Any		Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits							
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e Mary or 28a-	Director	10e. Street and Number		10f.	Zip Code 2122		Og. Citizen of What Cou United St				
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-003 d within giene. ther th	E O	12 Years 17. Father's Name (First, Middle, Last)		Stud		's Name (First, Middle,	N/A Maiden Surname)				
21215-0036 util be filed within 7 Mental Hygiene. marked other than c event, the Medica	æ	Anthony Dino DeAng				clene Lynn	•				
Baltimore, MD 21215-0036 Deprmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departmet of Filed and Montal Hygiene. Important: If item 77 is marked ofter than "natural", or items 23a or 23a-f she Afflory or other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Type, Mr. Timothy Hoffman	Print) Family		•	nber or Rural Route Nur 1 Dundalk,	mber, City or Town, State	e, Zip Code) 21222			
e, M 1 and 2 Health item 2		20a. Method of Disposition	20b. Pla		Name of cemetery,	Date	20c. Location - City or				
MOC Pages sent of nat: If	4	1 X Burial 2 Cremation 3 1 4 Donation 5 Other Specify:	Nemoval mom state	Stanisla	'	12/3/2012	Baltimore	, Maryland			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee	emi (atrol)	1 22 Name Duda	and Address of Facility 1-Ruck Fund	eral Home o	f Dundalk,	Inc.			
Physician		23a. Part I. Enter the disease, or complicat		1 7922	Wise Ave.	Dundalk.	Marvland 2	1222 Approximate Interval			
/Medical			_{ine.} Itiple Blunt Force Injur	ies				Between Onset and Death			
		h	to (or as a consequence of):								
	iner	cause. Enter Underlying Cause	to (or as a consequence of):								
d sit	xam	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):					1			
Box 68760, death certificate be executed he attending physician and for use as the burial - transit	Medical Examiner	dd	MENDED								
760, cate be physici he buri											
Box 68760, death certificate be exite attending physician of for use as the burial.	Physician/	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of deat	2 Fetal de		c pregnancy	Month I	Day Year			
BO) he death	hysi		Unknown			11 200- 1014	5 (0).				
f, P.O. Be ires that the de signed by the I be detached f	ğ	Part II. Other significant conditions con	tributing to death but not resi	uiting in the under	ying cause given in Pa		obacco use contribute to s 2 ✔ No 3 ☐ Pro				
of Vital Records, og Physician: The law require this certificate has been simeral director, page 2 should t	Completed					24a. Was		utopsy findings available completion of cause of			
Reco The lav	mo:						rmed? death?				
Vital Rec ysicinn: The his certificate director, page	Be	25. Was case referred to medical examiner?	ital: 1 Inpatient 2 E	D/0-4	26.Place of Death		D. 11				
n of Vital diog Physician: After this certif: funeral director,	5	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury 2	R/Outpatient 3 28b. Time of Injury	DOA Outer4	? 28d. Describe	Residence 6 Othe	r: Scene			
- = - \ \ \ \	atior	1 Natural 5 Pending 2 Accident Investigation	Nov 25, 2012 (April 2012)	2201 hrs	1 Yes 2 ✓	No Driver auto	SUVcollision				
Division pital or Attendi cours after death.	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At hom (Specify) Interstate/Ex		tory, office building, e		Street and Number or Ru State) Bridge on I-695, Balti				
1		29a. Certifier 1 Certifying Physician:	To the best of my knowledge	, death occurred a	t the time, date and pla	ace, and due to the cau	se(s) and manner as stat	ted.			
To the Hos within 24 h To the Fur completely	Medical		the basis of examination and d manner stated.	d/or investigation, i		curred at the time, date					
	~	29b. Signature and title of certifier	-	07	29c. License number O.C.M.E.		29d. Date signed (Mo				
		30. Name and address of person who com		,							
		Russell Alexander MD. Ass 31. Date filed (Month, Day, Year)	sistant Medical Examin		Baltimore Street,	Baltimore, MD 21	223				
Regis	tate trar	NOV 2. 8. 2012	oz. rogistiai s bigitaldi	arkel			00	3 <u>L</u>			

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			State of Maryland / Dep		Mental Hygie	ne 2012 3812	n		
		_	Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg.		O		
П	Physicia Medic		Phyllis Kirkham Dunn		Month 13	Day Year 3. Time of Death 1:20 P	М		
-	Examin		4a. Facility Name (if not institution, give street and number)		4c. County of Death				
1			8810 Walther Boulevard #2317 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Parkville		Baltimore			
i.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 081-12-6337 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 2/3/192	9. Birthplace (State or Foreign New Jersey	дп		
	land show dat	tor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limit	ts		
	Mary 28a-f notifie	Director	MD Baltimore Parkvil			1 ☐ Yes 2 X 1	Vo		
	vith the 23a or st be I	ral	10e. Street and Number 8810 Walther Boulevard #2317	10f. Zip Code 21234	US	Citizen of What Country?			
	eath v tems er mu	Funeral	11 Marital Status 12 Was Decedent Ever in LLS 13	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,			
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ⚠ Never Married 2 ☐ Married 1 ☐ Yes 2X No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XXNo Specify:	Rican, etc.)	Black, White, etc. Specify: white			
15-0	72 hou "natu edica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki	ing	b. Kind of Business/Industry			
212	within 7 jiene. er than the M			oo NOT use retired) Eretary	I	nsurance			
pue	ntal Hyg ed other: event,	To Be	17. Father's Name (First, Middle, Last) Henry Gordon Dunn		e (First, Middle, Maio	•			
aryl	ould b nd Me mark maric	ľ	19a Informant's Name/Relationship (Type Print)	ing Address (Street and Number or Rura	K. Kir				
Š	nd 2 sh ealth a n 27 is ertrau		Chrictophor Cohrabashas	W. 56th Street					
Baltimore, Maryland 21215-0036	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		Atlanti	c Crematory 11/	16/12 G	Location - City or Town, State len Burnie, MD			
Balt	permit. Departr Imports any inji		21. Signute of it neral Selvice Licensee	2. Name and Address of Facility Har 221 Grayburn Di	rman Fun rive Ste	eral Service G Glen Burnie 21061	1D		
F			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between			
Y	Medical		Immediate Cause (Final disease or condition resulting in death) a. hes makes a large final disease or condition a.	arthritis		Onset and Death			
-	Examiner		Due to (or as a consequence oi).						
	Bit d	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	ite be executed hysician and the burial-transit	Exan	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):				_		
90	e be ey ysiciar e burie	ical	d						
876	tificate ng phy as th	Med	IF FEMALE:						
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year			
9. O	that th	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?			
ds,	quires en sigr	ted b	ASCVO		1 ☐ Yes	2 ☑No 3 ☐ Probably 4 ☐ Unknow	√n		
Division of Vital Records,	The law re ate has be page 2 sho	Completed			24a. Was an autopsy performed 1 Yes 2		e		
ta 	clan: ertifica ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check					
Ž	Physi r this c eral dir	2	1 ☐ Yes 2 ☑ No ☐ No ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death ☐ 28a. Date of injury ☐ 28b. Time o	,	me 5 Residence	e 6 Other (Specify)			
0 UC	nding ath. :: After ie fune	icate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury	work? M 1 Yes 2 No	zed. Describe flow if	ijury occurred			
Divisio	al or Atte s after dea il Director ed in by th	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office					
_	ne Hospit n 24 hour se Funera pletely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investigation only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred at	the time, date and pl	ace, and due to the cause(s) and manner sta	ated.		
	To the within to the complex c	_	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)			
	10		a more	058646	Wo	ovember 15, 2012			
	a M		30. Name and address of person who completed cause of death (Item 23a) (Type, I	0 1	Parkuit	- MD 21231	C		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	negistra	alf	NOV 2 8 2012 / A South						

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	1	1 State of Maryland / Department of Health and Certificate of Death	d Mental F	lygier Reg. I	2111	2 38121			
Physician	/	1. Decedent's Name (First, Middle, Last) Grace Eleanor DePalma	2. Date of Month	Death	Day 17 Year	3. Time of Death 2012 8:30 PM			
Medica Examine	-	4a. Facility Name (if not institution, give street and number) Roland Park Place Nursing Home 4b. City, Town, or Location of Dec Balti	eath		4c. County of De				
Funeral Director		5. Social Security Number 213-38-2783 6. Sex 1		Birth Day Year	1919 9. B	irthplace (State or Foreign Sentrocky			
and show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
Maryl 28a-f	Director	MD Baltimore				1 ► Yes 2 □ No			
with the 23a or	runeral L	10e. Street and Number		10g.	Citizen of What C	•			
, , <u>, , , , , , , , , , , , , , , , , </u>	2	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Am Black, Wh	ite, etc.			
ours al atural" cal Exe	ered	3 ★ Widowed 4 □ Divorced If Yes, Give Year or Dates. 1 □ Yes 2 ★ No Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation		16h	Specify:	White			
21215	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Home Maker	working	160.	. Kind of Busines Own Hoπ	,			
Aaryland Sebolic Sebolid be filed vand Mental Hygy 7 is marked other raumatic event,	lo Be		Name (First, Midd d Parson		en Surname)				
Mary Ind 2 should selfth and N n 27 is ma er frauma		19a. Informant's Name/Relationship (Type, Print) Winifred DePalma /Daughter 19b. Mailing Address (Street and Number or F		-					
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam once.	2	20a. Method of Disposition 1	Nov 20 2012) 20c.	Location - City of Beltsvil	or Town, State			
Balti permit. Departr Importa any inji		21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Cremation and Fu 8717 Green Pastu				vland 21286			
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death					
Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death) A Due to (or as a consequence of): Sequentially list conditions A Due to (or as a consequence of):	on:						
xecuted n and al-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
be es siciar siciar buri	Cal Exa	that initiated events ' c. Due to (or as a consequence of):							
6876(certificate ding physise as the		IF FEMALE:							
Box death c he atter ed for u	ysicially	23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year				
requires that the been signed by the should be detach	ה ביים מ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				to the cause of death?			
Division of Vital Records, tal or Attending Physician: The law requires its after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be certificate. To Re Completed.	niibiere		pe	itopsy erformed?	prior to death?				
cian: The cian:		25. Was case referred to predical examiner?		es 2 🗹	No 1 L Y	es 2 No			
hysica physica this ce al direc	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing			6 Other (Spe	ecify)			
IVISION OF OF Attending Parter death. Director: After the funers of the funers.	l'alte.	27. Man of Death 28a. Date of injury 28b. Time of 28c. Injury at	28d. Descrik	e how inj	ury occurred				
DIVISION Attents all Directors de in by the		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		3f. Location (Street and Number or Rural Route Number, City or Town, State)					
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2 Madical Certificates To Reform		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place of the control of the pass of the pass of the control of the pass	ed at the time, da	te and pla to the cau	ce, and due to the use(s) and manner	e cause(s) and manner stated. as stated.			
To with		29b. Signature and title of certifier ▶ □ Isabelle The Gregor □ D/3 657		No		26,2012			
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEELE THEOR, 830 W. FO KSTREET, B.	ALTIMA	RE 1	70212	-11			
State Registrar		31. Date filed (Month, Day, Year) NOV 2 8 2012							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year Girard L. Dudley

4a. Facility Name (if not institution, give street and number) 5:23 PM Medical November Examiner 4b. City, Town, or Location of Death 4c. County of Death 48 Berkshire Road Baltimore Essex If Under 1 Year | If Under 24 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day, Year) Director 15 M 2 □ F 63 Usual Residence of Decedent Yrs. Feb 21, 1949 Maryland 23a or 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 48 Berkshire items Road United States 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ğ 1 Never Married 2 Married "natural", or 2 36 Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 3 Divorced Specify. Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene
Important: If item 27 is marked other the
any injury or other traumatic event, the A Protective, Services Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Dudley Parker Doris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Dudley /Wife 48 Berkshire Road Essex 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov 29 4 Donation 5 Other (Specify) Chesapeake Crematory 2012 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO144 Cremation and Funeral Alternatives 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Immediate Cause (Final espirat Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner P Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, there this certificate has been signed by the attending physician and completely filled in by the funeral director, bade 2 should he detached the completely filled in by the funeral director, bade 2 should be detached to the funeral director. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 151601 3 address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature

Registrar

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 26 2012 9:30A M Dougherty Helen Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keymar Frederick 13219 Detour Rd. If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral Director** 216-05-2142 1 ☐ M 2 🔀 F Yrs. 96 Nov. 27, 1915 Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Methoral Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Maryland Frederick Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13219 Detour Rd. 21757 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) post office postmaster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ည Annie Bentzel James Kiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i 8408 Grossnicle Ct. Walkersville, MD 21793 Larry Dougherty/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1 Removal from State any Injury or 4 Donation 5 Other (Specify) Keysville, MD Union Cemetery 11/29/2012 22. Name and Address of Facility Hartzler Funeral Home, P.A. Signature of Funeral Service Lic attarine S. Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1115854 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be de Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number D0031058 M. () 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10200 Coppermine Rd. Woodsboro, MD 21798 Gene Ashe 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 8 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARGARET R. DICKERSON NOVEMBER 2012 2:45p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCRIST HOSPICE CENTER TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 218-26-3457 **Director** 1 🗆 M 2 🖫 F 7-22-1923 VIRGINIA 89 Yrs 10c. City, Town or Location 10d. Inside City Limits Director rai", or items 23a or 28a-f s Examiner must be notified tXXYes 2 ☐ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 802 WILBERT AVE. 21212 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💯 No Specify: BLACK Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other then traumatic event, the Mentan traumatic event eve Elementary/Secondary (0-12) College (1-4 or 5+) CARETAKER NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LILLIE MAE TEAGLE ANDREW HOLMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 JACQUELINE WILLIAMS (DAUGHTER) 1125 WILLINGIE CT. BALTIMORE, MARYLAND 21202 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of IImportent: If ite
eny Injury or ot 1 Donafion 5 ☐ Other (Specify) ZION CEMETERY 11-24-2012 BALTIMORE, MARYLAND nyica Licensee JONATHAN: D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uiseasa or many) Examine Due to (or as a consequence of): or Attending Physicien: The law requires thet the death certificate be executed physicien and s the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day 1 Yes 2 Unknown ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SACRAL DECUBITUS Records, 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown CERO BROVASCULAR ACCIDANT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 🗆 No Yes 1 Yes 88 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence Hospital 2 No ြု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Cher (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No after death. Director: Aft 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. 4 Homicide filled in by determined building, etc. (Specify) within 24 hours a
To the Funerei C
completely filled Medical Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier mpleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOVEMBE 10:40 AM TON Medical 1.201 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE HEARN BALTIMORE **Funeral** Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 1 □ M 2 🗓 F 5-27-1918 MARYLAND 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28e-f show other treumatic event, the Market Experient is set to mail at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyres 2 No BALTIMORE N/A MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 USA 1717 N. MONROE ST. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced BLACK Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC HOUSEKEEPING -10--0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLARENCE GASSAWAY WILLAMENA CAREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRY L. WATERS (SON) 1406 N. ROSEDALE ST. BALTIMORE, MARYLAND 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Hamportent: If Ite eny injury or ot 1XXBurial 2 Cremation 3 Removal from State MARYLAND NATIONAL 11-29-2012 LAUREL, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Euroral Servi Licensee JQNATTAN D. HIBN R22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21-27 N. MONROE ST. BALTIMORE. MARYLAND 21217 23a. Part I. Enter the disease, or complications that caused shigk, or heart failure. List only one cause on such line Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Pnysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death signed by the a Id be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe death? 2 🗆 No 1 🗌 Yes ☐ Yes Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 🗌 Yes 2X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at o the Hospital or Attending P thin 24 hours after death. I the Funeral Director: After to impletely filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who compl eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. I. Decedent's Name (First, Middle_Last) 2. Date of Death Month Physician/ 54 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Alice Manor Nursing Home Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 3iru., Country) <u>MD</u> 213-18-5672 88 Hours (Month, Day, Year) Director April Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director N/A MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ral", or items 23a o Examiner must be 21215 Funeral 4303 Belvieu Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Special Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Woodward and Elementary/Seconday (0-12) College (1-4 or 5+) Food Technition 12th N/A Lothrop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Helen Cornish မှ George Wing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2433 Calverton Hei Baltimore, MD 21216 Linda Cornish/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cernetery, crematory or other place)
Woodlawn Cemetery 1 Burial 2 Cremation 3 Removal from State 11/29/12 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly D. Cro. 2700 Edmondson Ave. Balto., Cromartie F/S Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death hysician/ quence of): disease or condition resulting in death) / Medical Due to (or as a cons **Examiner** emin Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of haemmha Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed⁴ 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Other: 2 ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending Natural 2 No 24 hours after death. Funeral Director: A Investigation the f Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year, D 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAW ST Ente 308 BALTIMOREMD 21441 1478 KMI MD

DHMH 17 Rev 7/2009

State

Registrar

NOV 2 8 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lydia Ρ. **Eline** 33,00 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/AGood Samaritan Hospital Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hou*r*s Director 587-09-5713 1 M 2 D F Aug. 5,1950 62 Mississippi Usual Residence of Decedent iral", or items 23a or 28a-f ehow Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Baltimore Baltimore Co. MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4708 Mawani Road 21206 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married δ 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates er than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Years Housewife Own Home marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental ٥ Harold White Estelle Stonestreet . Page 1 and 2 should b tment of Health and Mer tent: If item 27 Is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Religione. Maryland 21206 Baltimore, Mary 19a. Informant's Name/Relationship (Type, Print) Mr. Michael F. Eline (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Importent: If it
any injury or o 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State cemetery, crematory or other place) Hilltop Service Corp. 11/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Signature of Funeral Service License Gregory E. Reed Duda-Ruck Funeral Home of Dundalk, Wise Ave Dunda1k 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any hading to immediate Examine if any, hading to immedicause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physicien: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 12 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) 21 □ № Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၉ → Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature Date signed (Month, Day, Year) 16-0 ath (Item 23a) (Type Print) m ð 32. Registra State Registrar

12-08771 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard Erdek State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ Medical Examiner Erdek Richard 4a. Facility Name (if not institution, give street and number) Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 155-78-1095 1 X M 2 F Usual Residence of Decedent 10b. County 10c. City. Town or Location Pages I and 2 should be filed within 72 hours after death with the Maryland per not of Headth and Mental Hygiene.

other traumers. Baltimore Director 10e. Street and Number 76 Vista Mobile Drive Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 2 X No Yes 4 Divorced If Yes, Give Year or Dates: 3 Widowed ۾ 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years 17. Father's Name (First, Middle, Last) Be John O. Erdek, Jr. ္ 19a. Informant's Name/Relationship (Type, Print) Mark H. Borris (Friend) timore, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Department of Important: Unjury or other Donation 5 Other Specify 21: Six oture of Funeral Service Light ee Devin 15 Physician failure. List only one cause on each line Medical a. Gunshot Wound of Chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed AMENDED the attending physician led for use as the burial -UNPENDED

Reg. No. 3 Time of Death 2. Date of Death Month 1616 hrs November 18, 2012 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreign Country) Months Days Hours Min. June 6,1979 10d. Inside City Limits 1 Yes 2 X No Dunda1k 10f. Zip Code 10g. Citizen of What Country? United States 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc White 1 Yes 2 X No specify: Specify 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Home Improvement Contractor 18.Mother's Name (First, Middle, Maiden Surname) Maryjo McGrath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Dinaden Circle Pikesville, Maryland 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Dulaney Valley Mem. Gdns11/24/2012 Timonium, MD 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth Month Day Year 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed by ector, page 2 should be detach ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 P ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject shot Nov 18, 2012 Natural 1538 hrs Pending 1 Yes 2 ✔ No Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Rear of 3900 blk Woodhaven Avenue, Baltimore, MD determined (Specify) Auto 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 19, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 22a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State arkal Registrar

Box 68760

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of Vital

Division

the Hospital or Attending Physician:

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within 24 hours after death To the Funeral Director:

DHMH 17 Rev 1/2001 OCMF 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 26, 2012 DANA ELLIOTT 2:17 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12300 Rosslare Ridge Road Apt 307 Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye. 4/5/1934 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York **Funeral** 78 216-30-8583 **Director** 1 🗆 M 2 🖾 F . Hygiene. other than "natural", or items 23e or 28a-f show rent, the Medical Examiner must be notified at Page 1 and 2 should ue filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ent: If item 27 is mar led other than "natural", or items 23e or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21093 12300 Rosslare Ridge Road Apt 307 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 √ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Insurance College (1-4 or 5+) Human Resource Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Webster Tilman Martha Klives 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,21093$ Charles M. Elliott, Sr.∕ husband 12300 Rosslare Ridge Road Apt 307 Timonium, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importent: If it eny Injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. 11/28/2012 Towson, Maryland 22 Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 21. Signature of Funeral Service Licens 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a cardi disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury e Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death.
From the death certificate be executed becomes after death. ete has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7401 Osler Dr., Suite 103, TOWSON, 40) D112 MD -31. Date filed (Month, Day, Year)

Registrar

Elliott

Dana

12-08885 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK-UNK** State of Maryland / Department of Health and Mental Hygiene ANTOINE 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day November 22, 2012 Medical Examiner Antione Rocky Ellis Jr. 1440 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreign Country[VID Director Months Hours 1X M 2 F 03/23/1989 23 Yrs 216-23-6736 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore 28a-f show MO 23a or 28a-f show 1 X Yes 2 No hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 North Gorman Avenue 21223 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Specify: Black Divorced Widowed f Yes. Give Yee 1 Yes 2 No specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than 16 jury or other traumatic. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Home Improvement 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Antione Rocky Ellis Sr. LaDonna Teresa Cooper 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 N. Gorman Avenue Baltimore, MD 21223 LaDonna Cooper / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Arbutus Memorial Park 11.30.2012 Baltimore, MD Donation 5 Other Specify ignoure of Funera e 22 Name and Address of Facility
John L. Williams Funeral Directors, P.A. 4517 Park Hights Ave Baltimore, MD 21215 In I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure, List only one cause on each line Between Onset and /M_Edical a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed put Physician/Medical UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown the the Hospital or Atteoding Physiciao: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? \$ σ. 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available this certificate has b I director, page 2 sh autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other this 1 Yes 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Certification Nov 22, 2012 Division Natural Subject shot 1419 hrs 1 Yes 2 V No Pending completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 2000 North Forest Park Avenue, Baltimore , MD determined (Specify) Park/Recreation Area 4 Momicide

Death

Year

2 No

29d. Date signed (Month, Day, Year)

November 23, 2012

31. Date filed (Month, Day, Year) State Registra NV 2 9

29g. Signature and title of certifier

Laron Locke MD.

Medical

32. Registrar's Signature

and manner stated.

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OGME

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 3. Time of Death Month. Physician/ 1:08AM Medical 4a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death 4c. County of Death Examiner more tarkwa 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Funeral Year Months Min. Country Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State death with the Maryland r then "natural", or items 23a or 28e-f sho the Medical Examiner must be notified at Director 1 🖪 Yes 2 🗌 No Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21216 owynns Tar Kwa 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. δ 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Completed It Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden 0VC Important: If item 27 is Baltimore, 20a. Method of Disposition 20b. Place of Disposition (N Department of ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signafure of Funeral Service L reene 23a. Part 1. Enter h disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death UNO Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): \ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires thet the death certificate be executed Lause (Disease or injury After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ☐ Yes 2 ☐ No 9 I IInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner?

1 ☐ Yes 2 No Be 26. Place of Death (Check only one) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Denth

1 Natural

2 Accident

3 Suicide

4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one) 29b. Signature and title of certifier 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Desai 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 28 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#9perFH, G934, 1274/2012, WS

State of Maryland / Department of Health and Mental Hygiene For Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov Physician/ John Owen Freeman $20\overset{\text{year}}{12}$ 1:22 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Oliio Davs 162-24-6414 Director 1 1 M 2 □ F 80 Yrs. Feb. 10, 1932 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other then "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 18003 Mateny Rd. #215 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Ś 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Builder / Developer Building Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Geraldine Jones Brice Rav Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 18003 Mateny Rd. #215, Germantown, MD Barbara Shatto Freeman / Wife other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If i any injury or o 1 Durial 2 Cremation 3 Removal from State Chesapeake Crematory 11/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee Name and Address of Facility app Funeral and Cremation Services 33 Gist Ave., Dilver Spring,MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final Physician/ ardiac disease or condition resulting in death) Medical Tie to (or as a consequence of): €xaminer Sequentially list conditions, if any, leading to immediate cause Entar In Janying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 66242 241 son who completed cause of death (Item 23a) (Type, Print) Medical Center Drive Rockville 9901 MD ego Z 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month aurine Gibson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF THE CHESAPEAKE LINTHICUM ANNE ARUNDEL Social Security Number 6. Sex Me (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min Country) Director 218-32-7709 1 DM 2 D 77 10/1/1935 MD Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at Director 28a-f MD ANNE ARUNDEL LAUREL 1 🗌 Yes 2 🔀 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 8523 WOODLAND MANOR DRIVE 20724 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 X No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally hydry or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRESIDENT AND CEO 4 CREDIT COUNSELING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ VINCENT STEPHEN CATALANO JOANNA FRANCES JORDANOVSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL SLOBODA - HUSBAND 8523 WOODLAND MANOR DR. LAUREL MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation *5 ☐ Other (Specify) 11/28/12 GLEN BURNIE, ATLANTIC CREMATORY of Funeral Service Licensee 22. Name and Address of Facility SKARDA FUNERAL HOME Molles 2829 HUDSON ST. BALTIMORE MD 23 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital [교 1 🗌 Yes Other: 2 4No 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No I Director: A 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Tertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) icense number

State Registrar 30/Name and address of person who completed cause

LEVEN EVE

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

objeath (Item 23a) Type, Print)

445 Defense Highway

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Santos Tista Gonz		EZ S	tate o	of Maryla				Health and	Mental	Ну	giene	jibie.	7 .	0 0010
Physician		Registrar 1. Decedent's Name (First, Midd	ile,Last)			ertifica	ale or	Death		12	Re 2. Date of Deat	g. No. Z	. ا ك	3. Time of Death
Medical Examine	er	SANTOS TISTA	GONZA	LEZ							Month November	Day Yea 23, 2012		0855 hrs
		 Facility Name (if not instituting the street of the street			41	b. City, Town, or Location of Death Baltimore			4c. County of De					
Funeral	7	5. Social Security Number	6. Sex		7. Age (In yr	s. last birtl	hday)	If Under 1 Year	If Under 24	Hrs.	8. Date of Birt	h(MM/DD/YYYY	9. Birl Foreig	hplace (State or
Director		None	1 XX	M 2 F	46		Yrs.	Months Days	Hours	Min.	02/17/1	966	n Watemala	
any	F	Usual Residence of Decedent 10a. State 10b. County			Inc. C	ity, Town	or Locatio							10d. Inside City Limits
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the M	5	2423 East Fayette	Stre	et Apt 2				21231				Gua	tema]	a
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er deal	-			1 Yes If Yes, Give Year	2 XX No	>		res 2 No				Specify:		m
urs aft		15. Decedent's Education (Spe		or Dates	e completed) 16a. [Usual Occupation				16b. Kind of Bu		
5 72 bo		Elementary/Secondary (0-12)		College (1-		٠ ا	during mos	st of working life. [OO NOT use	retire	d)			•
5-0036 led within 7 Hygiene. other than	Completed	unk.				Ma:	intena					Cemeter		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hypgers. Emperorate If it item 32s, or 28s-f sho importer. If item 32s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Eliment Director.		17. Father's Name (First, Middle Guillermo Tista	, Last)						3.Mother's N arlota			laiden Surname)	
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Ore,		20a. Method of Disposition 1 XXBurial 2 Crematio	п з 🏻	X Removal fro	m State	cremato	ory or othe	on (Name of ceme r place)			Date	20c. Location -	City or	Town, State
Baltimore, permit. Pages 1 an Department of Hes Important: If ite		4 Donation 5 Other S			G	iuatema					/2012	Guatemala		
Bal permi Depa	Į,	Signature of Funeral Service	in X	r CMAI	(is)		22. Na	me and Address of	r Facility M R∩ad Ra	itch Itir	nell-Wied Tome Man	defeld Fur cyland 212	neral 212	Home Inc
Physician	Ť	23a. Part I. Enter the disease, o failure. List only one cause	r compli	cations that ca	used the dea	ath. Do no	t enter the	mode of dying, s	uch as cardi	ac or r	espiratory arre	est, shock, or hea	art	Approximate Interval Between Onset and
/M i al		Immediate Cause (Final disease	a. A	1coho1			ion							Death
		or condition resulting in death)	D b.	ue to (or as a	consequence	e of):								
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		ue to (or as a	consequence	e of):								
rednsit	E	(Disease or injury that initiated events resulting in death) Last	C	ue to (or as a	consequence	e of):								
and and		T UNDENDED	d		32 27	282-	f no	me,g93	4 17-3	_13) em			
a significant		X UNPENDED F FEMALE:					Tabe	me; 3632	112 3	12		T		
ox 68760 suth certificate to attending physicate to be as the business as the business.	2	3b, Was decedent pregnant in t past 12 months?	he	23c. If yes, or 1 Live bir		egnancy 2	Feta	Ideath 3	Ectopic pre	gnand	су	23d. Date of Month		ay Year
Box 68760, he death certificate bb the attending physic hed for use as the burderian/Mor	3	1 Yes 2 No 9 Un	known	4 Pregna	nt at time of	death 5	Othe	(Specify)						
D. Bc		Part II. Other significant condi	tions o			t resulting	in the un	derlying cause giv	en in Part I.		23e. Did to	bacco use contri	bute to	the cause of death?
Division of Vital Records, P.O. B tall or Attending Physician: The law requires that the destable deed to the destable of the destable of the funeral director, page 2 should be detached be driftication: To Be Commission by Webwartification: To Be Commission by Webwartification:								, ,					_	ably 4 🗹 Unknown
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Records, The law require. ficate has been sign, page 2 should be	5									weren	perform	med? d	eath?	_
ital Recition: The scentificate rector, page		25. Was case referred to medical examiner?	-						f Death (Che	ck on	ly one)			
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Visic or Atte iter dez birecto in by th	3		stigation	28e Place		_1		factory, office bui	Iding, etc.	2	8f. Location (S	treet and Number	or or Ru	ral Route Number, City
Division o spital or Attending hours after death. neral Director: After filled in by the fune Centification:	5	4 Homicide dete	rmined	(Specify)	Mul	lit-F	amily	Apt.			or Town, St Apt 2	^{ate)} 2423 F Baltimo	re,	yette St. D.
Division of Vital Records, P.O. Box 68766 To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Purearal Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the behalf certification: To Be Commisted by Physician/Ma		29a. Certifier 1 CertifyIng Pone) 2 Medical Exa	hysicla miner: (n: To the best On the basis of	of my knowled	edge, dea n and/or in	th occurre	d at the time, date n, in my opinion, d	and place,	and d	ue to the cause the time, date a	e(s) and manner	as state	ed.
To To Com		29b. Signature and title of certific	8	and manner sta	ited.			29c. License				29d. Date signe		
O V.		The N	1	11: 1	TA	4.0	>	O.C.M	.E. 00	ME		November		
O O O PRIOR	13	30. Name and address of person					, P.			_				
of Vo.		Theodore M. King, Jr. 11. Date filed (Month, Day, Year)			nt Medica pistrar's Sign		ner 90	00 W. Baltimo	re Street	Bal	timore, MD	21223		
State Registra	-	NOV 2 8 20	12	A LANG	Jonal a Sigil	1	wed	,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G934 12/10/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 21 Physician/ Year 2012 РМ Melvin J. Geffner 12:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 1121 University Blvd., West #1006 Montgomery Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Hours Director 129-24-8158 1 K) M 2 | F Yrs 10-16-1928 New York Usual Residence of Deceden should be filed within 7z nous and and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show arrived other than "matural", or items 25a or 28a-f show arrived other than "matural", or items 25a or 28a-f show arrived other than "matural". 10b, County 10d. Inside City Limits 10c. City, Town or Location Director MD Montgomery Silver Spring 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States #1006 20902 1121 University 81vd., West Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Director US Government - HUD 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Bloomstein Harry Geffner 1 and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8354 Rocky Spring Road, Frederick, Maryland 21702 Gail Bree - Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 eny injury or other t 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/25/2012 1 Durial 2 Cremation 3 Removal from State Judean Mem. Gardens Olney, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee Edward Sagel ac 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Acure Myscardial hypotron Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate course. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHIOME RENT MENEGERESE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been siç r, page 2 should t Completed AGREAT FIDRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate funeral director, pag 1 ☐ Yes 2 🗹 No 2 No or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 😿 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 2 🗌 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 0 Heel up derres 1/26/2012 D19192 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3941 FERRARA DRIVE WITSAZON, UID BARRY HECHE, MD 31. Date filed (Month, Day, Year) NOV 2 8 2012

State

Registrar

arks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY 6934 12/06/2012 JH. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #18 Per FH G934 17/20/3032 TH State Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u>Garnes</u> Month L I Physician/ 13:40 Shirley Catherine 206 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Baltimore If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 213-30-0568 Director 1 □ M 2 💢 F 78 Yrs. 02/13/1934 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director N/A Baltimore MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ems 23a or Funeral 21218 U.S.A 428 Ilchester Ave. items? filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status "natural", or itel Armed Forces?

1 Yes 2X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Black Completed 3 - Widowed 4 X Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT_use retired) 16b. Kind of Business/Industry h and Mental Hygiene.
7 is marked other than "r traumatic event, the Med Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Westinghouse Assembler Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve onee. ၉ John W. Rhodes Cordelia Langi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7504~Ackermann~Ct.~Hanover,~MD~2107619a. Informant's Name/Relationship (Type, Print) Glenda Brown (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 28 1
Burial 2
Cremation 3
Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) On-Site Crematory Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home PA Fulton Ave. Balto., MD 21217 2140 N. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phytician/ day disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine sequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 110 Other: 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural injury 5 Pending after death. Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check within 2 To the I only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated no of certifier 29b. Signature a 29d Date signed (Month, Day, Year) 30. Name and address of tereon who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Union

KMY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per FH 6933 11/28/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death o7 Physician/ Month 7:52 ,JR 000 2012 Medical Facility Name (if not instit of Location of Death 4c. County of Death **Examiner** Town Moryland Medical IMORE 01 y If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Unknown Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 251-50-3248 **Director** 1**X**□M 2□F Yrs 09 36 22 76 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **Funeral** 21201 U.S.A. 833 West Pratts Street Apt 607 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: Completed 3 Divorced 16b. Kind of Business/Industry
League for the 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Handicapped 8th grade Laborer Be Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ္ George Goodwin Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keysha Goodwin-Daughter 1 and 2 s of Health item 27 4516 Furley Ave, Baltimore, Md 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State Holy Redemer 11/20/2012 Baltimore, Md. Signature of Funeral Service Licensee March F/H West Wabash Ave, Baltimore, Md 4300 3a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final disease or condition ⊳Physician/ oronal Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 9 Unknown 2 No page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? has performed? this certificate 2 No 2 J 1 Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No director, To Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation Could not be 6 🗌 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Attending 2012 Physician cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Item 23a) (Type, Print)
110 S. Paca St, Baltimore, MI) Everle MI Registrar's Signature State NOV 2 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Graham onald 9:24 25 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death Baltimore of Maryland Medical Center University If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug (5), **Funeral** Birthplace (State or Foreign Min. 354-42-5628 Months Hours Cillinois 1955 Director 28a-f shov 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Prince Georges Laurel ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8291 Londonderry Ct. 20707 United States or items 12. Was Decedent Ever U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give "natural" White 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) Manufacturing Fork Lift Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Graham Doris Kradle Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Payton /Wife 8291 Londonderry Ct. Laurel, MD 20707 20a. Method of Disposi 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Nov 2 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) 2012 201443 21. Signature of Funeral Service Licensee 22. NanGrematesonFamd Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Syncope Physician. disease or condition Medical resulting in death) consequence of) **Examiner** rady Cardia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last physician Physician/Medical Meningo Muelo Ce Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No page 2 should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed After this certificate has 1 Yes 2 No Yes completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospita Other: 2 No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 Natural 5 Pending Accident Investigation 24 hours after deatl Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the ! only one) 29b. Signature and 1376868836 and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar South

Grune street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 26 per phy g933 11-28-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 16, 2012 Month Henry George Gram 8:32 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 3935 Webster Road Havre de Grace 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 85 Director 341-20-5128 1 X M 2 🗆 F Illinois April 14, 1927 in then "neturel", or Iteme 23e or 28e-f ehow the Wedical Examiner must be notified at within 72 hours efter death with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Havre de Grace Harford Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21078 3935 Webster Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Q. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1945 Black, White, etc. δ 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: 1946 Specify: white 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) flled within 72 tel Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Law Enforcement Be or other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be file if Heelth end Mentel f Item 27 ie merked o ၉ Margaret Gruber Henry Gram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 3935 Webster Road, Havre de Grace, Maryland 21078 Charlene Gram Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pege 1 of Pepertment of Pepertment of Pepertment: If Its eny Injury or of Once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) R.A.Ferris & Company 11/19/2012 West Chester, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or combigations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). for use es the burlei-trensit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the ettending physicien end resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year be deteched 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 ☐ Yes 2 ☐ No 2 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 👿 Residence 6 Other (Specify) Hospital: မ 1 🗆 Inpatient 2 🖪 etions 3 DOA After this 24 hours efter death.

Funerel Director: After this letely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 ☐ Accident 3 ☐ Suicide 1 Yes 2 No М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 520 Upper Chisappake Dr. Suiz 308 Bel Air, MD 31. Date filed (Month, Day, Year) State NOV 28 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :27 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death latimor Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (in yrs. last birthday, Funeral Min. 1 \(M 2\) Yrs Director Maryland Nov. 19, 1939 Jsual Residence of show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ms 23a or 28a-f s must be notified MD Baltimore Owings Mills 1 🗌 Yes 2 🔀 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 9815 Bayline Circle 21117 U.S.A. within 72 hours after death items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc 0 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Completed by 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural" 3 XWidowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ permit. Page 1 and 2 should be Harry Gilner Helen Dockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 7712 Jewelweed Court Springfield, Virginia 22152 Helen Stewart daughter other 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Important: If it any injury or o once. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/27/2012 Baltimore, Maryland Crematory 21. Signature of Funeral Service Licer 22. Name and Address of Facilitation Pulped Pulped Pulped Funeral Home, Inc. 6500 York Road Balto, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on pach line Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 menths? Day Year Pregnant at time of death 1 ∐ Yes 2 9 ☐ Unknown the should be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director; After this certificate has t funeral director, page 2 autopsy 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 2 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accider injury 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 3 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Type, Print

who completed cause of death (Item 23a)

Registrar's Signature

and address of person

31. Date filed (Month, Day)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 24. Day 2012 9:35P CORDELIA **PHILLIPS** GTI BERT Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Towson Edenwald 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral 1 M 2 XX Days Hours Min Months 03/102/192 Delaware 91 221-14-4826 Vrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director 1 Yes 2XX No Maryland Baltimore Towosn 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral USA 21286 800 Southerly Road items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent L.S. Armed Forces? Black. White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: 'natural", Specify: White Completed 3XX Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. Is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Estella Fisher Short Clarence E. Phillips Sr permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Wendover Road Baltimore, Maryland 21218 Son C. Gordon Gilbert Jr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Dulaney Valley Mausoleum 1XXBurial 2 Cremation 3 Removal from State 12/01/2012 Donation 5 Other (Specify) Timonium, Maryland 22. Name and Address of Facilit Mitchell-Wiedefeld Funeral Home Inc nature of Funeral Serv 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, of complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, on each lin Ap roximate erval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed iding physician and se as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Defeat death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Year Day Pregnant at time of death 5 Other (specify) the Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death?

1 Yes 2 No page 2 certificate has 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: ည 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After iniury work? Hatural 5 Pending death. 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 8e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who

31. Date filed (Month, Day,

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of death (Item 23a) (Type, Print)

Begistrar's Signature

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			State Registraramend #10e&f 1. Decedent's Name (First, Middle, Last)	Per INF	G934	129f	, 8934 3776916	12-7 e gf _h L	−12 sm Death	1 2	Date of De	Reg. N	2012	2 38 42
	Physicia		MARION K. HICKS								Month NOV	D:	y Year 2012	3. Time of Death
	Medie Examir										-14U V -		. County of De	
-	<u>) </u>		STELLA MARIS HOSP					MSON					BALTI	MORE
	Funeral Director		5. Social Security Number 014-12-1568 Usual Residence of Decedent 6. Sex 1									-6 9. E	Birthplace (State or Foreign Country) MA .	
A.M.	Aaryland 8a-f shov tified at	rector	10a. State 10b. County Maryland Baltimo:	re	10c. City	y, Town or L	ocation	Ba	altimo	re Co	untv			10d. Inside City Limits 1 ☐ Yes 2√√No
00:	with the I	Funeral Director	10e. Street and Number 2300 Du. 14 Offspring Ct	laney Val	1ey	Rd.	10f. Zip		21093 21128			10g. C	itizen of What (Country?
3036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show mati event, the Medical Exeminer must be notified at	Ď		2. Was Decedent E Armed Forces? 1 ☐ Yes 2 🗓 M If Yes, Give Year or Dates.		5. 13	. Was Deced If Yes, spec	ify Cuba	spanic Origin n, Mexican, F	? (Specify	Yes or No- n, etc.)		14. Race - An Black, Wh	nerican Indian, Colored
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R 2.	uld e f M∈nta nar.ed iati ev	၉	Victor E. Kerr						4	Jenn	e Cam	pbel	.1	
NOVEMBER 21 Baltimore, Maryland	2 should be shou		19a. Informant's Name/Relationship (Type Alan C. Smith Hicks	(Grands (Son)	son)	l .	•		ond Number of Ct. Pe	erry H	Hall,		Town, State, 2 21128	' '
NOI imore	Page 1 and ment of Hea ant: If item ury or other		20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Ce	emetery, cri	position (Name ematory or of 1 Ceme	her plac	,	01 ^{ate}	012		ocation - City o	
Balt	permit. Page 1 Department of Important: If if any injury or o		21. Signature of Funeral Service Licensee	ma			22. Name and		s of Facility			uner	al Home	'
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused	the death									Approximate Interval Between
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09	te be executed hysician and the burial-transi	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequ	ence of):	-							
HICKS Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of the control of	2 🗌 Fetal	I death 3	☐ Ectopic p ☐ Other (sp		у				23d. Date of d Month	delivery Day Year
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TCKS	sian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?					26. Pla	ice of Death ((Check only		2 £3 N	ا ا	es 2 Q No
HI F Vita	Physic this co al dire	ပ္	1 ☐ Yes 2 🗷 No				ent 3 DO		4/N Nursi	ing Home	5 🗌 Resi	dence (Other (Spe	ecify)
AN on of	ath. r: After	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident □ Investigation	28a. Date of injur (Month, Day,	Year)	28b, Time of injury	of 26	Bc. Injury work?			Describe l	how injur	y occurred	
MARIAN Division	al or Atte s after de l Directo ed in by t	Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.	ry - At hor (Specify)	me, farm, s	treet, factory,	office			Location (S City or Tov			lural Route Number,
	a Hospit 24 hour e Funera detely fille	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examine) Only one) 3 Certifying Nurse F	r: On the basis of ex	amination	and/or inve	stigation, in n	opinio	n, death occur	rred at the t	ime date a	and place	and due to the	e cause(s) and manner stated
_	Voithir	~	29b. Signature and title of certifier					License		7(1)	7		te signed (Mon	
)		30. Name and address of person who com	pleted cause of de				<u>)</u>	عد	140)		1004M	pen 21, 2018
7	Stat	e.	ERNESTINE WRIGH	HT, M.D. 32. Registrar			DULANE	Y VA	LLEY F	ROAD		TIMO	NIUM 1	MD 21093
	Registra		NOV 2 8 2012	de tente		rake	7	_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20a, perFH, G933, 11/28/2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 2012 9:08 PMM Margaret Helena Heckner Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAltimore Glen Meadows Nursing Center Glen Arm If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F 12/17/1924 Florida Director 87 217-20-8762 Usual Residence of Deceden 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Glen Arm 23a or 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 21057 U.S.A. 11630 Glen Arm Road - Apt.216 items Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ò 2 1 Never Married 2 Married ☐ Yes 2 🔀 No hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White "natural", 3 XWidowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Veser George Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Ithica Court - Fallston, Maryland Robert D. Heckner (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 11/26/2012 Baltimore, Maryland 21. Signature of Fund Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between
Onset and Death Immediate Cause (Final CYESTIVE Physician/ disease or condition resulting in death) Medical CARDIO MYO PATHY **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine (or as a consequence of): that the death certificate be executed and that initiated events resulting in death) Last to (or as a consequence of) burial-1 attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Month Year Pregnant at time of death g 🗌 Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed SENILE DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11/26/2012

Registrar
DHMH 17 Rev 7/2009

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ROLLIAK (ROSS 120 ADS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Mosty Day EAZEL 1,35AM NORNI 2012 Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c County of Death GWYNN Home OAK BALTO If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Sex 1 M M 2 □ F 87 Min. Year Yrs. Director ROANOICE. VA ·a 28a-f shov 10a. State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** GWYNN 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a 2120 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, et ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Whit 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Westinghouse 15. Decedent's Education (Specify only highest grade completed) ouse other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha ctrica ENGINEER Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alford lizabeth 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number GWYNN OAK, MD 21207 Health a Wife 6825 CAM 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place 27-12 CREMATION HANOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) hn C. GREENE FUNERAL SERVICE permit. 21. Signature of Funeral Service Licensee 8728 L 21133 RANDALIS TOWN MD 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ROSTATE Onset and Death Physician/ METASITATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for se a consequence of attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Li Fetal Some Pregnant at time of death Unknown in the past 12 months? been signed by the atte should be detached for Day Month Voar g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, HRONIC FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director; page 2 No 1 Yes 2 EN Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death Check only one) examiner? Hospital Othe al No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 🗌 Residence 6 🔲 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28598 0 asuein 26 WN) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM (AICHAM) MD PO BOX 0 BOX) WINGS MILL mi ASNE 1525 21117 State NOV 2 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland	/ Department of Health and	Mental Hygiene	
		700	State Registrar		Certificate of Death	Reg. No.	2012, 38145
	Physicia Medic	n/	+ Decedent's Name (First, Middle, La	Hance		2. Date of Death Month Day	3. Time of Death 9.14 Q4M
	Examin		a. Facility Name (if not institution, give	-	4b. City, Town, or Location of Death	40.0	County of Death
	<i>*</i>		Gilchrist /7 5. Social Security Number 6.8	05,0100 Sex 7. Age (In yrs. last	hirthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director			M 2 DF	Months Days Hours Min.	(Month, Day, Year)	Country)
			Usual Residence of Decedent	38		9-23-195	
	f sho	혅	10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Mar 28a- notifie	Director	N)D	109/	1 Limore 10f. Zip Code	In Citie	en of What Country?
	ith the		10e. Street and Number	1 81-00-6	21213	Tog. Citiz	USA
	ems ?	Funeral	1710 W. Hor	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	4. Race - American Indian,
336	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "matural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☐ No Specify:	l l	Black, White, etc. pecify: White
21215-0036	hour natur dical	lete	15. Decedent's (Specify only highest g	Education	16a. Decedent's Usual Occupation (Give kind of work done during most of wo		d of Business/Industry
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2	d with tygier ther t	00 1	17. Father's Name (First, Middle, Last)		10 Mest/C	me (Eirst, Middle, Maiden St	OMES 17C
anc	be filed ental Hy ked oth ic event	10 E	//	Hance	E/len	Bowen	arriantej
Maryland	should the and Me is mark aumatic		19a. Informant's Name/Relationship (19b. Mailing Address (Street and Number or Be		own, State, Zip Code)
	12 shou alth and 27 is m ir traum	- 5	Taha tha Ed	dins Davahter	1010 10 1	rad Gwynn	Dak MO 21201
Je,	of Health fitem 27 rother tr		20a. Method of Disposition	20b. Plac	ce of Disposition (Name of hetery, crematory or other place)	Date 20c. Loc	cation - City or Town, State
Ē	Page ment c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	I heliloval ilolii State	ing Park 12-	1-2012 Ba	Kimore
Baltimore,	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Tuneral Covice Live	isee	2. Name and Address of Facility Va	/	
<u> </u>	20 E # 9	Ш	1/0/05/	101553	4905 York Road		re, MD 2/2/2
			shock, or heart failure. List only	one cause on each line.	Do not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hmyotroph		5	Onset and Death Wee K
-	Examiner		residing in dealing	Due to (or as a conso quer	nce of):		
		je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen	nce of):		
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events				
	execu an an ırlal-tr	Ä	resulting in death) Last	Due to (or as a conseque	nce of):		
9	death certificate be executed ne attending physician and ed for use as the burlal-transit	dical		d		<u> </u>	
	rtifica ling pl	Ĭ,	IF FEMALE:	23c. If yes, outcome of pregnance			and Data of delivery
Box 687	ath ce attend for us	Sian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fetal of Pregnant at time of de	death 3 Ectopic pregnancy		3d. Date of delivery Month Day Year
m.	sician: The law requires that the death certifica certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown			
P.0	that the red by deta	<u>~</u>	Part II. Other significant conditions	contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
ţs,	n sign	Completed by				1 ☐ Yes 2 ☐	□ No 3 □ Probably 4 ♥ Unknown
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<u> </u>	stor.	Be (25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Ch		II in t
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n o	Attending Physician: The law requires that the sr death. sctor: After this certificate has been signed by they the funeral director, page 2 should be detach	Certificate:	1 Natural 5 ☐ Pending	(Month, Day, Year)	l8b. Time of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe flow injury	occurred
Sio	deatl deatl ctor: y the	ĬĔ	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Injury - At hom	ne, farm, street, factory, office		Number or Rural Route Number,
Division of Vital Records, P.O.	al or A s after I Dire	2	4 ☐ Homicide determine	building, etc. (Specify)		City or Town, State)	
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 Medical Exa	miner: On the basis of examination a	dge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred knowledge, death occurred at the time, date and	d at the time, date and place,	and due to the cause(s) and manner stated.
_	To the within 7 To the comple		29b. Signature and title of certifier	I uns	29c. License number		e signed (Month, Day, Year)
			30. Name and address of person wh		23a) (Type, Print)	105, Tow.	son Md 21204
	Sta	10	31. Date filed (Month Pay Year)	32. Registra s Signal		1000	201 1 (1) 2120
	Registr		NUV 2 8 2012	32. Registrats Signat	avec		
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cassandra Hardy-Blow 2012 6:10 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months 219-50-1934 Director 1 🗆 M 2 🔀 F 63 Yrs. 11/26/1948 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State or then "neturel", or items 23a or 28a-f sho Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pege 1 end 2 should be filed within 72 hours after death with t ment of Health end Mentel Hyglene. tent. If item 27 is marked other then "neturel", or items 23a iury or other treumetic event, the Medical Examiner roust by Funeral 5007 Sunset Rd. 21215 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 2 Yrs Levindale Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Andrew Hardy ည Viola Williams 19a. Informant's Name/Relationship (Type, Print) (Niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Hardy-Flowers 4203 Star Circle Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pege 1 e
Department of H
Importent: If ite
eny Injury or ot 1 X Burial 2 Cremation 3 Removal from State Arbutus 11/30/12 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph H. Brown Jr. 2140 N. Fulton Ave. 21. Signature of Funeral Service Licensee Funeral Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death) mont Due to (or as a consumence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physicien and for use as the burlei-transi Cause inisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) Pregnant at time of death signed by the er 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

the Maryland

Baltimore, Maryland 21215-0036

After this certificate hes been significate has been significated funeral director, page 2 should be a second to be second within 24 hours after death.

To the Funerel Director: A completely filled in by the formal completely filled in the formal completely fille

Hospital or Attending Physicien: The lew requires thet the death certificete be executed

Division of Vital Records, P.O. Box 68760

Be Completed by Physician/Medical 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy med N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Hornicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Charles St. Balto md 21204

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

(Check

only one)

G-BMC 6701 N. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland / Department of Health and Mental Hygiene

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Debra Ann Hoffman	Stat 1- For State Registrar	e of Maryland / I	Department o Certificate o		Mental Hyg	iene Reg. i	201	2 3814				
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, L Debra A.					Date of Death	av Year	3. Time of Death 1549 hrs				
	4a. Facility Name (if not institution, and 3210 Meadow Valley Dr			4b. City, Town, or Lo Abingdon			4c. County of Death					
Funeral Director	5. Social Security Number 6. 215-66-3523		(In yrs. last birthday) 55 _{Yr}	If Under 1 Year Months Days	If Under 24Hrs. 8 Hours Min.	Date of Birth (1 April1	MM/DD/YYYY) 9. Bir 0 , 1 9 5 Foreig	thplace (State or in MD untry)				
any	Usual Residence of Decedent 10a. State 10b. County	110	Oc. City, Town or Loca	tion			····	10d. Inside City Limits				
E	MD Harf	ord	Abing	don				1 Yes 2 No				
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	10e. Street and Number 3210 Meadow	Valley Dr	rive	10f. Zip Code	21009	10g.	Citizen of What Coul USA	ntry?				
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ours after	15. Decedent's Education (Specify	or Dates:	leted) 16a. Decede	nt's Usual Occupation	n (Give kind of work		Specify: 6b. Kind of Business/	ndustry				
5-0036 ed within 72 hour bygiene. tygiene than "natu the Medical Exar Completed	Elementary/Secondary (0-12) 11th	College (1-4 or 5+)	nost of working life. D emaker	O NOT use retired		own hom	ie				
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2121 ould be fill d Mental I: s marked fic event,	Charles Hurt Nancy Brain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,											
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limore, Pages 1 a unent of He tant: If it	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, Date 11/29/12 Baltimo											
Baff permit Depar Impo injury	21. Au haure of Funeral Service Li	ensee	22.	Name and Address of	. 300		Ave. Bal					
Physician /Medical `xaminer	23a. Part I. Enter the disease, or co failure. List only one cause on Immediate Cause (Final disease	mplications that caused the each line. a Methadone		the mode of dying, su	uch as cardiac or re	spiratory arrest,	, shock, or heart	Approximate Interval Between Onset and Death				
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executed an and al-transit	events resulting in death) Last Due to (or as a consequence of): d. AMENDED 23a, 27, 28a-f, per me, g934 12-10-12 sm											
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the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and rupletely filled in by the funeral director, page 2 should be detached for use as the burial - transit director: To Be Completed by Physician/Medical Ex	1 1 Yes 2 V No 9 Inknown											
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Vital Rec ysician: The I his certificate I director, page	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 500		f Death (Check only		-id 0 -d 04	. 0				
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Division of Pripiel or Attending Phours after death. Terral Director: After trifilled in by the funeral Certification: T	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 X Could r	fd 11-24-	-12 fd 3:4	1 pm		f. Location (Stre	eet and Number or Ru	iral Route Number, City				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	(citability	sician: To the best of my k			Al and place, and du	e to the cause(s	, MD . s) and manner as stat	ed.				
To the Hos within 24 h To the Fus completely Medical (29b. Signature and title of certifier	ner:On the basis of examinand manner stated.	nation and/or investiga	29c. License r			d place, and due to the					
	30. Name end address of person wi	und	oth (Itom 22a)	O.C.M.			November 25, 20					
<u> </u>	Laron Locke MD. Ass	istant Medical Exan	niner 900 W. B	altimore Street,	Baltimore, MD	21223						
State Registrar	MOI/ O O COLO	32. Registrar's										
DHMH 17 Rev 1/2001	00	Server S.	A CORTOIN	AL								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ CAROLYN November 23rd 2012 JOHNSON 6.30PM Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death MEDSTAR HARBOR HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Nonth, Day, Birthplace (State or Foreign Country) **Funeral** 218-28-4682 Director 11 1935 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location Director MD1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian ģ 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Cine kind of work done during life. DD NOT isseretired) (Specify only highest grade completed) Elementary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) other's Name (First, Middle, Maiden Surna Town, State, Zip Code) 21136 Nephew 20a. Method of Disposition Burial 2 Cremation 3 Removal from State loodlawn Cemetery 4 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CAD Sequentially list conditions, if any leading immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Day within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 110 00072328 completed cause of death (Item 23a) (Type, Print) RAGNURAM CHAVA MEDSTAR HARBOR HUSPITAL

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) NOV 2 8 2012 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State o	of Marylar					Mental F		ZUI	2	38149	
			Registrar 1. Decedent's Name	e (First, Middle	Last)		Cer	tificate of Death 2. Date of Death					0.		3. Time of Death	
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	Medic Examin		4a. Facility Name (if			nber)		4b. City, To	wn, or L	ocation of Dea	th		c. County of E	Death		
			717 Nort							.more						
	Funeral		5. Social Security Nu		6. Sex	7. Age (In yrs. I		If Under 1 Months		If Under 24 Hrs Hours Min		Birth <i>Day</i> , Year)	g.	Birthpl Countr		
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and	shov d at	tor	10a. State	10b. County		10c. Cit	ty, Town or Loc							d. Inside City Limits		
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ם פ	ty Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) King Memorial Park 11/29/2012 Woodla atura of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, M											ld 2	21215			
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spital C	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		29a. Certifier 1	Certifying	Physician: To the	best of my knov	vledge, d eath o	occurred at t	he time,	date and place	, and due to th	e cause(s)	and manner	as state	d.	
Ho Ho	he Fu	Medical	(Check 2 only one) 3	☐ Medical E	xaminer: On the ba Nurse Practitione	sis of examinations: To the best of	on and/or invest my knowledge	tigation, in my , death occur	y opinion red at the	i, death occurre e time, date and	d at the time, da place, an d d ue	to the caus	ce, and due to se(s) and man	the cau ner as s	se(s) and manner stated. tated.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month Maurice E . Jones 1132 A M 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Since MUSPITAL OF BOLLHMORE Baltmore CITY . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 217-30-5028 Director 09 76 28 36 ir than "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits daeth with the Maryland 10c. City, Town or Location Director 1 Yes 2 ☐ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3805 Granada Ave 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Paga 1 and 2 should ba filad within 72 Depertment of Health and Mantal Hygiane. Important: if itam 27 is merked other than any injury or other traumetic event, the Magnobie. Elementary/Secondary (0-12) College (1-4 or 5+) 9th grade Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Jones Clara Parran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwynnvale Road, Pikesville, Md 21208 Sylvia Tapp-Cousin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cher (Specify) 11/30/2012 Baltimore, Md Carmal Sign sure of Funeral Service License Marchd Address of Webst 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRAHON PREJMONIHS Physician/ disease or condition Medical esulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) signad by the attanding physician and d ba detachad for usa as tha burlal-transit Hospital or Attending Physicien: Tha law raquiras that tha daath cartificeta ba axacutad that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown within 24 hours aftar death.

To the Funeral Director: Aftar this cartificata has bean si completaly filled in by the funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 2 1 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-24-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE RIC SINAL SOLNIN 31. Date filed (Month, Day, Year) NOV 2 8 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of rtificate of			giene 2012	38151			
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ith Dav Year	3. Time of Death			
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036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	☐ Yes 2 🛣 No Yes, Give 1 ☐ Yes				Black, Whi				
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Baltimore, Maryland	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		71. Stenatur Funeral Service Licenses	Smight	M ²	2. Name and Add	rs weith						
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visio	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director, After this certificate his completed filled in by the funeral director, page	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Arbuilding, etc. (Spe				28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James W Johnson State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death James Wesley Johnson Jr. Month Day November 24, 2012 Medical Examine 1402 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** If Under 24Hrs Days Director Months Hours Min Country) Mi) 1 X M 2 F 22 08/16/1990 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD n/a Baltimore 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be modified as Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2602 Oswego Avenue 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes Widowed 4 Divorced Yes. Give Yeer 1 Yes 2 X No specify: Specify: Black \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 unemployed n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Wesley Johnson Sr. Iowna I. Poyner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iowna Poyner / Mother 2602 Oswego Ave Baltimore, MD 21215 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Zion Cemetery 11.29.2012 Baltimore, MD Denation 5 Other Specify 22 Name and Address of Facility John L. Williams Funeral Directors, P.A. ure of Funer Service Lice At 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate name. Enter Underlying Course Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED signed by the attending physician be detached for use as the burial AMENDED e Hospital or Attending Physicians. The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy past 12 months? Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No After t 28a. Date of Injury (Month, Day Year) Nov 24, 2012 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Subject shot 1332 hrs d in by the f Pending 1 Yes 2 ✔ No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 1300 Laurens Street, Baltimore, MD determined (Specify) Liquor Store 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b/Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 25, 2012 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8, per fh, g933 11-28-12 sm
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Carolyn Johnson 3:15p. м Nov 20 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5505 Fern Park Avenue Baltimore Felite of Birth Abb 7, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthdav) Funeral 1 🗆 M 2 🔀 F Months Davs Hours 67 212-46-0372 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Examiner must be notified MD N/A Baltimore ₩ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5505 Fernpark Avenue 21207 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other trainmetic access. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Xivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Rail Road Ret College (1-4 or 5+) Supervisor 12th 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Hunter Mary Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scot Johnson/Son 5505 Fernpark Ave. Balto., MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metro Crematory 11/26/2012 Catonsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 21. Signature of Funeral Service Licenses 8 23a Part 1 Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ END DISGASE STAGE KIDNEY disease or condition YEMS Medical resulting in death) Due to (or as a consequence of **Examiner** DIABETES MEDLINS -20 YEARS Sequentially list conditions, if any, leading to immediat cause. Enter Underlying Cause (Disease or iinjury that initiated events Que to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HYPERTENSION 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Pay, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident 112 120 Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completed fil 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D2929 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M GERARD LOWDER LAND MARK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ 7:50 P M ĬĬ Dorothy M. Kehl 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Baltimore Rosedale Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday, **Funeral** Min. (Month, Day, Year, Hours Director 1 🗆 M 2 💢 F 212-28-8443 07/25/1930 82 Maryland Usual Residence of Decedent 28a-f show 10b. County ir than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No MD Baltimore Perry Hall 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral 9822 Gunforge Road 21128 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Yes Maryland 21215×9036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 ☑ Widowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed with Department of Health and Mental Limportant: If them 27 is many injury or other. 12 Homemaking Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anthony Izner Stella (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Borowy (daughter) 9822 Gunforge Road - Perry Hall, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 11/27/2012 Baltimore, Maryland Signature of Fun Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Pancreatic a Metastatic disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a conse uence of Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been sirirector, page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Ves 2 No 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ဂ္ 1 Inpatient 2 NER/Outpatient 3 IDOA After this 5 Residence 6 Other (Specify, 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work?
1 ☐ Yes 2 ☐ No Natural 5 Pending n 24 hours area he Funeral Director: Aft Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 22/12 00074452 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Proitin Sangrampurkar, 9000 Franklin Square Drive Baltimore, M.) State NOV 2 8 2012 Registrar

DHMH 17 Rev 06-2011

F	Physician
	/Medical
	Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1	For State Registrar	State of M	aryland		tificate of L			Reg. No	2112	38155			
cian		1. Decedent's Name (First, Middle, Terry Kowa	, Last)					2. Date of De Month Novem	Da	y Year 26,2012	3. Time of Death			
lical ine		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or	Location of Deat	h	4c	. County of Deat	h			
		Johns Hopkins Bay	view Medical	Center		Baltimore				N/A				
l r		5. Social Security Number 216-54-0578	1 X M 2 □ F	ge (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ay, Year) 195	Co	hplace (State or Foreign untry) cyland			
	- 1-	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation					10d. Inside City Limits			
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1	١	1113	timore				alk		10 0	Service of Million Co.				
ä	5	10e. Street and Number				10f. Zip-Code	21222			tizen of What Co				
2	₫	1825 Merritt B	lvd.							United S				
2	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, V								 Race - Ame Black, White 					
Ž	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:									Specify: W	nite			
potologo	- אונינים	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education t grade completed) College (1-4 or	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	Ì	Kind of Business	•				
8	9 Years Shipping & Receiving American									rican Na	ational Can			
	n) 17. Father's Name (First, Middle, Last)													
		Henry Andrew	Kowalevicz	Z			Evelyr	n Marie	Boddice					
F	Henry Andrew Kowalevicz Henry Andrew Kowalevicz 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										Zip Code)			
		Mrs. Shirley M	1. Kowalevic	z		5 Merritt		Dundalk			21222			
	Ì	20a. Method of Disposition 1X Burial 2 ☐ Cremation	2 □ Bomoval from State		lace of Dispo emetery, crer	sition (Name of natory or other place	ce)	Date	20c. L	ocation - City or	Town, State			
		4 ☐ Donation 5 ☐ Other (Sp	oecify)	Gar	rdens	of Faith	Cem, 12	/1/2012	Rc	ssville	, MD			
Olice		21. Signature of Funeral Service 223. Part 1. Enter the disease, or			D.	2. Name and Addre uda-Ruck	Funera1	Home of	Dur	ndalk, I	nc. 222			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
ing Ohyaniainian (Mandi	Ilysiciali/incul	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Months 9 Unknown									livery Day Year			
		Part II. Other significant condition	ons contributing to death	but not res	ulting in the	underlying cause g	iven in Part I.			use contribute t	o the cause of death?			
of of a second	Completed							24a. Was auto peri 1 X-Yes		prior to death?	utopsy findings available completion of cause of			
0	וי	25. Was case referred to medical					26. Place of De	eath (Check only						
15		examiner? 1 17 Yes 2 □ No	Hospital: 1 ☐ Inpat	tient 2 🛭	ÆR/Outpatier	nt 3 🗆 DOA Oth	ner: 4 Nursing	Home 5 ☐ Res	idence	6 ☐ Other (Spe	city)			
	- 10	27. Manner of Death 1 Natural 5 Pendin investig	28a. Date of Inj		28b. Time o Injury	Wor		28d. Describe	how inju	ury occurred				
	a Lillica	2 Accident Investig 3 Suicide 6 Could in 4 Homicide determine	not be 28e. Place of in	njury - At ho etc. (Specif)		eet, factory, office		28f. Location City or To			dural Route Number,			
	Medical Ceriffication.	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	Me	29b. Signature and title of certifier				29c. Licens	se number - 006111	5		ate signed (Mon	th, Day, Year) 26, 2012			
	ŀ	30. Name and address of person	who completed cause of	f death (Iter	n 23a) (Type						ore, MD, 21224			
State		31. Date filed (Month, Day, Year)	32. Regist	trar's Signa			7340	Eastern F		o, Partiill	J. J, 141D, 2122			
stra		NOV 2 8 2012	Bened	A. 1	back	7								

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Josephine Karbonik 2012 Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 186-20-6273 1 □ M 2🎾 F Yrs. 85 Oct. 11,1927 Pennsylvania 28e-f ehov J. Hyglene. other than "netural", or items 23a or 28e-f eho vent, the Medical Examinar must be notified at Paga 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ent: If Item 27 is marked other than "netural", or Items 23a or 28e-f eho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No MDBaltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7401 Wenig Avenue 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 M Married Completed by Baltimore, Maryland 21215-0036 Specify. White 1 ☐ Yes 2 ☒ No · Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 Years Eastpoint College (1-4 or 5+) Ith and Mental Hygle 27 Is marked other r treumatic event, # Data Entry Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicola Golia Mary Grace Venuto 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Nicholas L. Karbonik 7401 Wenig Avenue Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If Ite any Injury or ot once. 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) Gardens of Faith Cem. 11/28/2012 Baltimore, Maryland Sign ture of Funeral Service Licensee That 1 e isher 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. NI 7922 Wise Ave. Dundalk. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Granie disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be axecuted
 24 hours after death.
 Funeral Director: After this certificata has been signed by the attending physician and attending physician and if for use as the burlai-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month after daath. Director: After this certificata has been signad by the a I in by the funeral director, page 2 should be detached t Part II. **Other signific**an**t conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aft To the Funeral Dis completaly filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -18acs mo D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

NOV 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Kirby 8:30 Nov 2012 Eleanor Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River Ivy Hall Nursing Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days Hours (Month, Day, Year) **Funeral** Months 1 M 2 TX F **Director** 507-20-4638 Yrs. April 3, 1917 Iowa 95 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State must be notified at Director 1 Yes 2 X No Essex MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 23a Funeral United States 21221 1 Lancer Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) th and Mental Hyglene. ?T is marked other than "natural", or items traumatic event, <u>the Medical Examiner m</u>u 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No within 72 hours after death 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Glenn L. Martin Co. Elementary/Secondary (0-12) Air Craft Production 8 Years Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed 1 Department of Health and Mental Hyg Important: If item 27 is marked othn any injury or other traumatic event, 17. Father's Name (First, Middle, Last) Johanna Drilling မ Clemmens Reicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, Maryland 3463 Yorkway Mr. Robert Clemons (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Baltimore, Maryland 11/27/2012 Oak Lawn Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Neiser 22. Name and Address of Facility al Home of Dundalk, Inc. Duda-Ruck Funeral Home of Dundalk, 21222 Michael Ave. Dundalk, Maryland ligh 7922 Wise Muse 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MOT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) g Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2.☐No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 110 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Suicide City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year) State NOV 2 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27 2012 Physician/ Busan DE Kher GYrnes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Copper Ridge Sykesville Carcoll County Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Min (Month, Day, Ye 216-46-996-Director 1 M 2 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland N/A Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5700 Kennore Road 21210 USA or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Never Married 2 Married Completed by 2 X No 1 Yes If Yes, Give hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5-F Elementary/Secondary (0-12) School Teacher/Administrator Education and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Valentine Koerber Mary Lee Gardner 19a. Informant's Name/Relationship (Type, Print)

L. Bcyan Koecbec (B 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau (Brother) 5700 Kenmore Road, Baltimore, Maryland 21210 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Metro Crematory, Inc. 11/29/2012 4 Donation 5 Other (Specify)

21. Signature of Fundral Service Description States Marctin D. Lawson Baltimore, Maryland MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Par Kinson's disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No for Dav Year Pregnant at time of death 1 Yes 2 5 9 Unknown P.O. by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has 1 Yes 2 No of Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) 1 Yes 2 Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division ours after death.

eral Director: Af
filled in by the ft. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours : Funeral I Medical 1 ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2 only one) 29b. Signature and title of certifi ompleted cause of death (Item 23a) (Type, Print) Eldersburg MD 21784 Illiam lan MD Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20b per fh. 9933 11-28112 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ .Month Day Year 7:40 AM 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11 zaketh enter N/A WYSING timere 8. Date of Birth (Month, Day, Year) 7-27-1926 Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Hours 1 🛛 M 2 🗆 F MARY LAND Director 218-18-3192 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Department of Health and Annual Hygiene.
Important if file 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. N/A BALTIMORE 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4221 COLBORNE RD. 21229 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes If Yes, Give BLACK 1 ☐ Yes 2 X No Specify. Specify: 3 Nidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SOCIAL SECURITY -12-FORKLIFT OPERATOR -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည THOMAS E. KELLY MARY L. BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA KELLY (DAUGHTER) 4221 COLBORNE RD. BALTIMORE, MARYLAND 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial /2 Crer nation 3
Removal from State 4 □ Donation 5 🗓 other (Specify) ENTOMBMENT WOODLAWN CEMETERY 4-2012 BALTIMORE, MARYLAND ALICENS OF THE PROPERTY OF A CHILD PROPERTY OF THE PROPERTY OF 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 18 X16 110 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury pue lo foi as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed VONOV and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical nemia Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
 5 Other (specify) Day Year Month Pregnant at time of death should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by TIGISM 1 ☐ Yes 2 🛱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital P 2 **X** No Other: 1 Inpatient 2 I ER/Outpatient 4 X Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury s after death. Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 \square Pending 1 Yes 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, yearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benson Avenue timure, Marylana MD 3326 31. Date filed Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.gedent's Name (First, Middler Last), Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Anne Arundel 720 Old Riverside Road Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours **Director** 217 32 8996 1 X M 2 □ F Maryland 76 07/10/1936 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 🕅 No Maryland Anne Arundel Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 720 Old Riverside Road 21225 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 9 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Yes. Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Forklift Operator Manufactoring 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anne Lambert Joseph Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Old Riverside Road Baltimore, Maryland 21225 Helen Lloyd / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2012 Baltimore, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listen Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Internying Cause (Disease or injury Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events

Pnysician/

Baltimore, Maryland 21215-0036

signed l page 2 funeral director,

this certificate

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Physician/Medical δ Completed Be Certificate: To

Medical

29a. Certifier

(Check

29b. Signature and title of

resulting in death) Last	Due to (or as a conseq	juence of):				
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 🗌 Ectopic			23d. Date of delivery Month Day Yea	ar
Part II. Other significant condition	s contributing to death but not re	sulting in the underlying	g cause given in Part I.		use contribute to the cause of dea	
				24a. Was an autopsy performed?		
25. Was case referred to medical			26. Place of Death (Che	ck only one)	7000000 00000000000 W	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	OOA Other: 4 \(\sum \) Nursing H	Home 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 Matural 5 Pending 2 Accident Investiga	tion	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred	
3 Suicide 6 Could no 4 Homicide determin			ry, office	28f. Location (Street ar	nd Number or Rural Route Number	Ģ

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 06-2011

ompleted cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 25, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:30 A.M Bernard Edward Lyons November 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Genesis Eldercare Hammonds Lane Baltimore 8. Date of Birth (Month, Day, Year) 09/27/1933 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Maryland **Funeral** 1**X** M 2□ F Months Days Hours 79 Director 212 30 9111 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Evandree host be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or U.S.A. 21225 5606 Park Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 🛣 No Specify: White Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 Is marked other that amy injury or other traumatic event, the green. Factory Worker / Foreman McCormick Spice Co. 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Brady John Lyons ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Lyons / Wife 5606 Park Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/29/2012 Baltimore, Maryland Bayview Crematorv 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Locate 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Box 68760. Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (cense number 29d. Date signed (Month, Day, Year) 11-27-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aviation Blud Glen Burnie MD 2/06/

Registrar DHMH 17 Rev 1/2001

State

Knnito/

31. Date filed (Month, Day, Year)

01 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perFH, G933, 11/28/2012 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 9, 2012 **Physician** LATANISHEN -RANCES levernber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗡 F Months Hours 246-Nacch 18,1925 North Carolina 60 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f shov "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 1 No Director MD Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 3305 Belsford Court Funeral 21222 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "nature any injury or other traumatic event, the Medical once," 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4 or 5+) Administration 12 Years Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winnie Bullis Coy Alexander Vickers ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7627 Charlesmont Road Dundalk, Maryland Sean Latanishen (Grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11/21/2012 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Greggy E. Reed 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition Physician BILATERAL resulting in death) //Medical Due to (or as a consequence of) Examiner MCA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed physician and Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 🔲 Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Month Day Year 1 ☐ Yes 2 No 9 ☐ Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 7 No 1 Tyes Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ↑ Natural 5 Pending investigation Injury М 1 Yes 2 No n 24 hours after death.

The Funeral Director: Af oletely filled in by the funeral properties of 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number KES-000 MOVEMBER 19,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HABELA 4940 Eastern Avenue, Baltimore, MD, 21224 32. Registrar's Signature State parka Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First Middle Last 2. Date of Death 3 Time of Death Physician/ Month 11 2012 00:38 Elaine Ruth Lipstein Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 8et.hesda Suburban Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days Months Hours Min. Director 070-26-2291 1 □ M 2 Ϊ F 80 New York 5-22-1932 Usual Residence of Dec 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director FI Jupiter Palm Beach 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States 1300 South A1A, Ocean Crest Apartment #425 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian. Armed Forces 9 1 Never Married 2 Married Black, White, etc. by 1 ☐ Yes 2 🛛 No If Yes, Give 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced White Completed Year or Dates Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Real Estate Sales Real Estate other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) h and Mental F ဂ္ Flizabeth Adler Herman Berger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 South A1A, Ocean Crest Apartment #425, Jupiter, FL 33477 1 and 2 s of Health item 27 Norman Lipstein - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Agudat Achim Cemetery 11-25-2012 Rotterdam. New York Signature of Funeral Service Licensee Edward Sage1 22. Name and Address of Facility Oanzansky-Goldberg Memorial Chapel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metabolic Cardiopathy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Metastatic Carcinoma of Endometrium Ascites Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical as 1 use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 Tyes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending Accident М 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Baltimore, Maryland 21215-0036 00 500 202 68760 Box P.O. Records, Elaine Division of Vital Hospital or Attending Physician: pstein filled in by 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certi 23044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 8600 Old Georgetown Road, Bethesda, Maryland 20814 Said Abolohassem Daee, MD Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #27,28A-F, PER ME G933 11/30/12 TRT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland, Shock Trauma Backimore NA 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) Director 223-40-4536 82 1 □ M 2 🗑 F 07-17-30 VA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f MD XX Yes 2 No Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4236 Flowerton Road 21229 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo African Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: 3 Nidowed 4 Divorced American Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home maker 9th Grade Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ David Clayton Annie Bivens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise A. Bunn-Daughter 3656 Hilmar Road Randallstown. Marvland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If it
any injury or of Lively Hope Bapt. Ch. 12-01-12 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Callao, VA. 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 232 Part 1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner EFRIFICATION REPORTED BY WE'DI Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has 2 🖼 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** 26. Place of Death (Check only one) 횬 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, 27. Manner of Death Certificate: 28b. Time of 1 A Vatural 5 Pending Mechanical Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined to becton Rd. Battimore Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 2012 rson who completed cause of death (Item 23a) (Type, Print) Southe Greene St Baltimae 21201 32. Regist State Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Navem 6:32 /M aNOSK 2012 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** Medstar Ha-bor 19/TIMONE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Min. (Month, Day, Year) 213 32 3223 Director 1 ☑ M 2 □ F 11/02/1933 Maryland or 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3723 Everett Street 21225 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmans. Elementary/Secondary (0-12) College (1-4 or 5+) Loftsman Coast Guard years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John J. Matanoski Emma Vina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Matanoski / Wife Baltimore, Maryland 21225 3723 Everett Street Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 11/26/2012 Glen Burnie, Maryland . Signature of Funeral Sery 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ tricular Medical resulting in death) Due to (or as a consequence of): Examiner tive Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\Bigcap \) Nursing Home \(5 \Bigcap \) Residence \(6 \Bigcap \) Other (Specify) 2 🗆 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature Hanover street Balknore Maryland 21225 31. Date filed (Month, Day, Year, State 2 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 8:20 Рм Physician/ 2012 Phillip Kent McCardell. SrMedical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Gilchrist Hospice Center Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Year) Days Min Months Hours Director 1 X M 2 - F 212-30-1163 Yrs March 2,1935 Maryland Usual Residence of Dece 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 XNo MD Baltimore Edgemere 10f. Zip Code 10g. Citizen of What Country? ۵ Funeral 21219 United States 7329 Geise Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates al Hygiene. d other then "neture event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Industry 10 Years Dispatcher 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mantal H Emma Blanche Edwards ဥ Paul Joseph McCardell 8 parmit. Pege 1 and 2 should be Department of Health and Man Important: If Item 27 is marke eny Injury or other treumatic once. Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Philomina Linda McCardell Edgemere, Maryland 7329 Geise Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 11/30/2012 Parkwood Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Michael Neiser Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave Dundalk, Maryland 21222. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final 150 cancel Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): physicien end s tha burlai-trensit or Attanding Physician: The lew requires thet the deeth cartificeta be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 **Director:** Aftar this certificete has baen signad by the ettending p d in by tha funeral director, page 2 should be deteched for usa es t IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 8 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lusplu 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes ျှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. ☐ Accident 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined To the Hospital o within 24 hours af To the Funerei Di completely filled In Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie Neverinsel 26 2012 rson who completed cause of death (Item 23a) (Type, Print) SI AARON 1 HANUES 6701 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month November 2012 McJilton Frances 10:10 AM Joyce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Director 218-26-1683 1 □ M 2 □XF 82 Yrs. Dec. 4,1929 Maryland 28e-f show 10a. State 10b. County 10c. City, Town or Location Pege 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mentel Hyglens. The Cast 12 merked other then "natural", or items 23a or 28e-f sho and it if it at unsetic event, it is Medical Examinar must be natified at ury or other traumetic event, it is Medical Examinar must be natified at 10d. Inside City Limits Director MD Dundalk Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3016 Dunglow Road 21222 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 12 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years 2 Years nterior Designer Interior Design Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edwin Pelter Virginia Belle Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Mackin (Daughter) 4224 Lynhurst Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o Important: If any injury or 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 12/1/2012 4 Donation 5 Other (Specify) Moreland Mem. Park Baltimore, Maryland Signature of Funeral Service Licensee Scott P. Gardnet 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 90171Vc 04 Car Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami signed by the ettending physicien end d be detached for use es the burlei-transit or Attending Physicien: The law requires that the deeth certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Yes 2 TNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physicien: The law requires within 24 hours after death.

To the Funerel Director: After this certificete has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29c. License number

State Registrar

DHMH 17 Rev 06-2011

pron 1860

Blackmo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

D00611

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Kelly McGroarty November 26. 9:00P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death Residence 5704 Roland Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours 164-14-1159 Director 93 XX M 2 D F 06/03/1919 Pennsylvania Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at Director 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland None Baltimore 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5704 Roland Avenue 21210 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1)(X) Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Priest Religious Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard J MdGroarty Ann Marie Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev William C Rickle SJ 5704 Roland Avenue Baltimore, Maryland 21210 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 11/30/2012 Donation 5 D Other (Specify) Woodstock, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc <u>6500 York Road Baltim</u>ore, Maryland 21212 igations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, acuse on each line. 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only one Immediate Cause (Final Physician/ Imona disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Deer Sequentially list conditions, if any, leading to immediate cause. (Size (Cause Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the 24 hours after death.

To the 24 hours after this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Hatural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) Waith D 52016 11/27/2012 Samona 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babtimore, MD 200 East

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of		1ental Hy	giene	00160			
			- State Registrar Certificate of	of Death		Reg. No 2 0 2	38169			
	Physicia Medic		1. Decedent's Name (First, Middle, Last) EDITH V. MATTHEWS		2. Date of Dea Month	Day Jula	3. Time of Death			
)	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Tow BALTIMORE WASHINGTON MED CENTER GLEI	n, or Location of Death	3	4c. County of Death				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y	0	8. Date of Birt	h 9. Birti	nplace (State or Foreign			
	Director		Usual Residence of Decedent			8/1931	MD			
	aryland a-f sho fied at	Director	MD 10b. County 10c. City, Town or Location 10c. City, Town or Location Pasadena				10d. Inside City Limits 1 ☐ Yes 2 X No			
	h the M 3a or 28 5e not	al Dir	10e. Street and Number 10f. Zip Co.			10g. Citizen of What Co	-			
	eath wit tems 2: er must	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	of Hispanic Origin? (Spe	cify Yes or No-	U.S.A.				
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "Hatural", or items 23a or 28a-f show quiter Z' is marked other than "Hatural", or items 2a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 【XMarried 3 ☐ Widowed 4 ☐ Divorced Year or Dates. If Yes, specify € 1 ☐ Yes 2 【XMarried 1 ☐ Yes 2 【XMarried 1 ☐ Yes 2 【XMarried Year or Dates.	Cuban, Mexican, Puèrto I K No S <i>pecify:</i>	Rican, etc.)	Black, White Specify: Bla	_			
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212	within rgiene. er thar t, the M		Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use reti 8th Homemaker	red)		Own Home				
Baltimore, Maryland 21215-0036	be filed ental Hy ked ott ic even	To Be	17. Father's Name (First, Middle, Last) George Caldwell	18. Mother's Name (First, Middle, Maiden Surname) Lilian Thompson						
Mary	should n and M 7 is mar raumat		19a. Informant's Name/Relationship (Type, Print) Roy Matthews (Husband) 19b. Mailing Address (Str. 7938 Don 1				Code)			
re, l	of Health of Health fitem 27 rother tra		20a. Method of Disposition 20b. Place of Disposition (Name o	f C	Date	20c. Location - City or	Town, State			
Him Him	Page nent ant: I		4 □ Donation 5 □ Other (Specify) Glen Haven	12/		Glen Burn				
Ba	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee Letter N. Welliams 22. James and A. 21. 40 1	N. Fulton	n Jr. Ave.	Funeral Ho Balto., MI	ome PA D 21217			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.		or respiratory arr	est,	Approximate Interval Between Onset and Death			
	Medical Examiner	(0. 7	disease or condition resulting in death) a. Due to (or as a consequence of):							
		ner	Sequentially list conditions, if any, leading to immediate b. MYOCARDIAL IN Due to (or as a consequence of):	FARCT101	<u> </u>		Unknown			
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
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6876	irtificat ling ph	/Mec	IF FEMALE:							
. Box (sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \[\text{Yes} \ 2 \] \text{No} \\ g \] Unknown \] 23c. If yes, outcome of pregnancy \\ 1 \[\text{Live Birth } 2 \] \[\text{Fetal death} \] 3 \[\text{Ectopic preg} \\ 4 \[\text{Pregnant at time of death} \] 5 \[\text{Other (specifing of the pregnancy \\ 1 \[\text{Live Birth } 2 \] \[\text{Fetal death} \] 3 \[\text{Ectopic preg} \\ 2 \] 6 Unknown \\ 2 \[\text{Unknown} \]			23d. Date of deli Month	very Day Year			
ls, P.O.	uires that th signed by Ild be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause TRACHEOSTOMY	e given in Part I.		obacco use contribute to				
cord	law requ has beer le 2 shou	Completed			24a. Was autop		opsy findings available completion of cause of			
al Re	an: The tificate tor, pag	Be Col	25. Was case referred to medical 2	6. Place of Death (Check	1 Yes		2 🗆 No			
Ĭ	hysici nis cer il direc	To B	1 Inpatient 2 ER/Outpatient 3 I DOA	Other: 4 Nursing Ho	me 5 Resid	lence 6 Other (Speci	fy)			
on of	nding P ath. : After tl e funera	cate:	1 Natural 5 Pending (Month, Day, Year) injury	Injury at work? 1 □ Yes 2 □ No	28d. Describe h	ow injury occurred				
Division of Vital Records,	l or Atte after dea Director	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	ice	28f. Location (S City or Tow	itreet and Number or Rur n, State)	al Route Number,			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my conly one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the	pinion, death occurred at	the time, date a	nd place, and due to the c	ause(s) and manner stated.			
	To the within 2 To the comple	<	29b. Signature and title of centifier 29c. Lic	ense number		29d. Date signed (Month	, Day, Year)			
	M		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	34357185			<u>U</u>			
	V.		Jonathan Craig Wendell, 301 Hospital Oriver 31. Date filed (Month, Day, Year) 38. Registrar's Signature	-, Wen Bu	chic, à	1001				
	Stat Registra		NOV 2 8 2012 Segistrar's Signature							

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ +01 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Z'mz 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months Hours 218-28-4305 Director 1 □ M 2 🗓 F 80 03/13/1932 r than "natural", or items 23a or 28a-f show the Modest Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 No OWINGS MILLS BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 111 SPECTATOR LANE 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ٥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the May Injury or other traumatic event, College (1-4 or 5+) Elementary/Secondary (0-12) MEDICAL MEDICAL SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ GREENBERG MILDRED GOLDBERG JOSEPH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 SHADED BROOK DRIVE, OWINGS MILLS, MD LEE MILLER/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ANSHE EMUNAH ATT 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State EMUNAH_RAITZ 4 ☐ Donation 5 ☐ Other (Specify) 11/25/2012 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused shock, or heart ailure. List only one cause on each line. use, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗆 Yes 2 No 3 🗆 Probably 4 🗀 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No 2 1 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag. Medical Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State NOV 2 8 201 Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

of Vital

cora Noakes		Please Type or Print in Black Ind. State of Maryland / Depart	elible Ink. Ensure All Copi ment of Health and Mental F		
		· -	ficate of Death	Reg. No. 201	2 3817
Physicia ledical Exami	an/	Decedent's Name (First, Middle, Last) Socora	Noakes	2. Date of Death Month Day Year November 17, 2012	3. Time of Death
		4a. Facility Name (if not institution, give street and number) 740 Poplar Grove St	4b. City, Town, or Location of Deat		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		s. 8. Date of Birth(MM/DD/YYYY) 9. I	Birthplace (State or
Director		220-19-2274 1 M 2 K F 24 Usual Residence of Decedent	Yrs. Months Days Hours Mi	For	eign Country) MD
any		10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ţ	MD NA Ba	altimore	F	1 X Yes 2 No
the Mar 3a or 28a	Director	740 Poplar Grove Street Apt	10f. Zip Code 21216	10g. Citizen of What Co	-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a no 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		erican Indian, Black,
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Jimore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after d ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or or other traumatic event, the Medical Examiner m		10th grade na 17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maiden Surname)	
2121 Ild be fi Mental narker event,	To Be	Bryant E. Noakes 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	roctor	ote Zin Code)
AD 2 shouth and 1 27 is remartic		Bryant E. Noakes-Father	226 S. Stricker S		
re, F s 1 and f Healt f item er frau		20a. Method of Disposition 20b. Place	ce of Disposition (Name of cemetery, matory or other place)	Date 20c. Location - City	
Pages Pages nent of		Tomovar nom otate		01/2012 Baltimo	ore, Md
Balt permit. Departu Import injury		21. Signature of Fugeral Service Licensee	22 Name and Address of Facility March F/H West 4300 Wabash Ave	. Baltimore, Mo	d 21215
Physician		2a. Part I. Enter the disease, or conquentiums that caused the death. Do failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interva Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	r		Death
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876C ificate ig phys s the bu	□/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth	2 Fetal death 3 Ectopic pregn	23d. Date of deliver	ery Day Year
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - transit	Physician/Med	past 12 months? 1 ✓ Yes 2 No 9 Unknown 1 Unknown		inchin inchin	Day (ea
Records, P.O. I The law requires that the cate has been signed by the page 2 should be detached.	হ	Part II. Other significant conditions contributing to death but not resu	lting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 Pr	
rds, require been si	Completed			24a. Was an 24b. Were	autopsy findings available completion of cause of
Reco	E			performed? death?	
ian:	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)	
Physic rr this		1 Yes 2 No Inpatient 2 EF		ng Home 5 Residence 6 ✔ Otr	ner: Scene
		Natural 5 Pending (Month, Day, Year)	Bb. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Jivisi I or Att after de I Direct	Certification:	Suicide Could not be	e, farm, street, factory, office building, etc.	28f. Location (Street and Number or F or Town, State)	Rural Route Number, City
1 5 6 PE		29a. Certifier 1 CertifyIng Physician: To the best of my knowledge,	death occurred at the time, date and place, an	d due to the cause(s) and manner as st	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated. 29b. Signature and title of certifier			
N	2	250. Signature and the or certifier	29c. License number O.C.M.E.	29d. Date signed (M. November 18, 2	
	-	30 Name and address of person who completed cause of death (Item 23		140veiliber 16, 2	LV 12
		Donna M. Vincenti, MD Assistant Medical Examin	,	more, MD 21223	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 8 2012	14. 8		
Regist	EL	IVUV & O CUIL (Busher B. Ja	Ked		

DHMH 17 Rev 1/2001 OCME 2006 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Robert L. Nelson, Sr. 10:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 094-16-2226 1 X M 2 - F 91 July 9, 1921 Massachusetts th and Mental Hygiane. 27 is marked other than "natural", or iteme 23a or 28a-f ehov traumatic evant, the Medical Evaminar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔽 No MD Baltimore Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road #702S 21093 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes. Give Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Maryland State Elementary/Secondary (0-12) College (1-4 or 5+) Civil Engineer 12 Port Authority Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lyman Barrett Nelson Kathryn Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Nelson, Jr. 8305 Bellona Avenue; Towson, son or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of important: If any injury or once. Hilltop Service Corp. 11/28/2012 Towson, MD 21. Signature of Functor Symbol Live 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician enhol aus Medical resulting in death) as a consequence of Examiner Franco montrs Sequentially list conditions, sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as months To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Anno 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? ☐ Yes 2 M N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) WOSD (ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident September 2012 UNIL M 1 ☐ Yes 2 🕅 No tall Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined assisted wing Facility home 2525 PETSPANCED, TIMOVIUM, M Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date/and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sias fure and title of certific November 27 2012 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2 8 2012

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 38175

	Registrar			Ce	ertificate d	of De	eath			R	eg. No.			
Physician/ edical Examiner	1. Decedent's Nam		le,Last) seph	Allen	01i	.vei	c		2	2. Date of Dea Month Novembe	ith Day	Year 012	3.	Time of Death 1345 hrs
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Funeral	5. Social Security I	Number	6. Sex	7. Age (In yrs.	last birthday)	rthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthpl						lace (State or		
Director	220-17-3	405	1 X M 2	0.0		M	nonths Day		Min.			F	oreign Count	n/)
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Nu 913 B		one Road				f. Zip Code			1		en of What ted Si		
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5-0036 led within 7 Hygiene. I other than the Medica	17. Father's Name		, Last)					18.Mother's	Name (First, Middle,			J	1
215 be file mtal H rked cent, ti		ph A.	Oliver,	Sr.				Cath	erin	e Cumm	ingha	am		
D 21 nould Mer is mar tic ev	19a. Informant's N	ame/Relations	ship (Type, Print)		19b. Maili	ng Add	dress (Stree	et and Numl	ber or Ru	ıral Route Nur	mber, City	y or Town, S	State, Zi	p Code)
MD id 2 sho lifth and an 27 is aumati	Mrs. Je	ssica	A. Olive	r (Wife)	913	B1	Lakisto	one Ro	oad	Glen :	Burn	ie, M	D 2	1060
G. Heal	20a. Method of Dis	,	۰. 🗆 -		Place of Dispo			metery,		Date	20c. Lo	ocation - Ci	ty or To	wn, State
Baltimore, permit. Pages 1 an Department of Hea Important: If item njury or other tr	_	Other S	n 3 Remov		illtop		,	Corp	11/	23/201	d т	owson	. Ma	ryland
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi edical Certification: To Be Completed by Physician/Medical Eisedical Expension and the property of the completed by Physician/Medical Eisedical Expension and the property of the completed by Physician/Medical Eisedical Expension and the property of the completed by Physician/Medical Eisedical Expension and the property of the completed by Physician/Medical Eisedical Expension and the property of the property of the completed by Physician/Medical Eisedical Expension and the property of the completed by Physician/Medical Eisedical Expension and the property of the completed by Physician/Medical Eisedical Expension and the property of the completed by Physician/Medical Eisedical Expension and the property of the completed by Physician/Medical Eisedical Expension and the completed by Physician/Medical Expension and the completed by Physician Eisedical Expension and the completed by Physician/Medical Expension and the completed by Physician Expension and the completed by Physician and Physician Expension and the completed by Physician and Physicia	1 Natural 2 Accident	5 Pen	ding Nov	ate of Injury onth, Day Year) 18, 2012	1336 hrs			Yes 2	ıc	ubject driv			collisi	on
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Divis Hospital or A 24 hours after Funeral Directely filled in b all Certific	4 Homicide		(0,000	Major Roa										es Rd, Glen Burnie,
To the Hos within 24 h To the Fur completely	Check only	Certifying P Medical Exa	miner:On the ba	best of my knowle sis of examination	dge, death occ and/or investig	urred a ation,	at the time, da in my opinion	ate and plac n, death occ	ce, and d curred at	ue to the cau: the time, date	se(s) and and plac	manner as e, and due	stated. to the c	ause(s)
Me 1 with 15	29b. Signature and	title of certific	and mann	er stated.			29c. Licens	se number			29d. D	ate signed	(Month,	Day, Year)
	MX	10.	6 01	110	7		O.C.	M.E.			Nove	ember 19	, 2012	2
	30. Name and add	ress of person	who completed	cause of death (Ite	m 23a)									
	Melissa Bra			Medical Exam		N. B	altimore S	treet, Ba	altimore	e, MD 212	23			
State	31. Date filed (Mor	th, Day, Year)	32	. Registrar's Signa	ture									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 per FH G933 11/29/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 145 AM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death Examiner 4c. 5. Social Security Number NIA 1th Mox If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birtholace (State or Foreign **Funeral** Days (Month, Day, Year) 0338 Months Min 21918 1 M 2 F Director 87 151925 Yrs MD or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Baltimore 1 Yes 2 No MD Gwynn Dak 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21207 6604 porina 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/8 condary (0-12) College (1-4 or 5+) Hainter Self Emoloyed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Brown illian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rice - nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 11-GWynn Oak Vathaniel Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Date ∠ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-8-12 Randallstown, mo 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service I 22. Name and Address of Facility Gary P. March FH270 Fredhillon Pass Balto. Mo21229 -0558 23a. P. M. En en by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she k, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ raumation disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Day to (or as a consequence of): Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): 5 Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, 27 Manner of Death 28b. Time of 28d. Describe how injury occurred CGT Struckother Subject of Ner of CGT Struckother VENICLES + Fixed OUTECTS 28c. Injury at 1 Natural Hospital or Attending 24 hours after death. 5 Pending pt 292012 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Medical 1, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ranie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:50a. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Baltimore</u> <u> Sinai Hospital</u> Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 247-80-5275 Director 1**X** M 2 □ F Yrs. 02 25 47 SC 65 Usual Residence of Deceden il Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21216 3336 Mondawmin Ave within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ XNo Specify: If Yes Give 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Building Mechanic Verizon 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Katherine Richardson Olin Pinckney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3336 Mondawmin Ave, Baltimore, Md 21216 DeAnna Pinckney-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State ŏ 1 X Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) 11/24/2012 Woodlawn, Md Woodlawn 21. Signature of Puneral Service Licer 22. Name and Address of Facility, March F/H West <u>4300 Wabash Ave, Baltimore, Md 21215</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one on each line, Approximate Interval Between Onset and Death Parkl condiac auchythmia Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Myran ensice Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 1 Yes 2 No tor: After this certificate has been signed by the a the funeral director, page 2 should be detached to 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Myrachole luclemia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical Division of Vital 8 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗆 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: Aft bletely filled in by the fur 2 Accident
3 Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Curtifying Nurse Practitioner: To the basis of my knowledge, death accurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the I only one) 29b. Signature and title of certifier Booning & Wila M.D D 19323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5356 REISTERSTOWN AD BALTIMORE MD21215 31. Date filed (Month, Day, Year) Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2:00 AM Plaks Medical Israel November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cherrywood Future Care Reisterstown
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 1 **™**M 2 □ F 100 Yrs 216-25-7629 Usual Residence of Decedent Apr 27, 1912 Russia , ...ai yiand 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Det artment of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturo" any injury or other traumatic and any injury or other any injury or other traumatic and any injury or other traumatic and any injury or other any injury or other any injury or other any or othe 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Owings Mills Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 Romney Ct Jnited States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed Specify: 3 ₩Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Abraham Plaks <u>Hannah</u> Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Igor Feldman /Son in Law Romney Ct. Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Nov 25, 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Hebrew Cemeter Gwynn Oak. Signature of Funeral Service Licensee 22. Name and Address of Facility M01493 Cremation and Funeral Alternatives 23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Va. 1241 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy or Attending Physician: The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day be detached g 🗌 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been sig ; page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? s after death.

Director: After this certificate has autopsy performed 1 Tes 2 No Yes 2 N filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Advursing Home 5 A Residence 6 Other (Specify) Hospital: 2 No ဖြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours at To the Funeral D completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00061199 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

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Registrar

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32. Registrar's

Jasop

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22 Physician/ Month [] 9-40 £ M Harold Parker Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITAL JAMARITAN BALTIMORE IVI 600 h . Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 227-14-0986 Director 1 M 2 F 88 Jan.9,1924 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland al Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 Sy Yes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 3725 Ellerslie Ave. 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc. þ 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 ☑ No Specify: If Yes Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 3 Baltimore, Marylahd 21215-0 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Kelly Brothers (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Labore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked c 2 Paul Parker Eva Jane Troggdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Toles, Jr (brother) 3725 Ellerslie Ave. Balto,Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location ~ City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery Dec.4,2011 Balto, Md 21. Signature of Foueral San Cultinus 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home Balto Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Disseminated Intravancy lar Medical resulting in death) Examiner Stage Secure nearly list conditions if any, leading to immediate cause. Enter Underlying Examine After this certificate has been signed by the attending physician and thuneral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Hypertension

Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ___ Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by so thyroidism 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy ahi tibrillation perform 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner # Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RE5000 11/22/2012 3 30. Name and address of impleted cause of death (Item 23a) (Type, Print) JUSTIN ECHOUFFO BALTIMORE. TCHEUGUI

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 🐔 Physician/ Month WILLIAM H. REICHART Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE BALTIMORE CITY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 212-36-4836 Days Hours Director 75 XX M 2 D F Vrs Nov. 2.1937 MD. Usual Residence of Decedent 10d. Inside City Limits ir than "naturai", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Ves 2 No Maryland Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4504 Hamilton Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2XXNo Black, White, etc. XX Never Married 2 Married Š If Yes, Give Year or Dates. 1 ☐ Yes 2x No Specify: specify:White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>vrs</u> Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Louis Joseph Reichart Elizabeth Frances Hoerner permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 6 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 Oakfalls Way Nottingham, Md. 21236 Robert Nickles (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Metro CRematory,Inc. 4 ☐ Donation 5 ☐ Other (Specify) 11-26-2012 Baltimore, Md Lassahn Funeral Home Baltimore, Md. 21236 Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rs. land 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or Trijury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancon 2 No 3 Probably 4 Nown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TIME 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ nours after death.

neral Director: After this of filled in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funerail Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lovember 30. Name and address of person who completed cause of death (Item 23a) [Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITEM#2/perME, G933, 11/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 21 burber 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center N/A Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 **X** M 2 □ F Yrs. 93 July 4,1919 Maryland Director 218-09-0878 Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits works 10c. City, Town or Location 10b. County 1 Yes 2 XNo Directo the Medical Examiner must be notified or 28a-f MD Baltimore Dunda1k 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number items 23a 21222 United States 7860 St. Gregory Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumation. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify WWII Specify: 2 317 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Steel Industry <u>Mechanical Foreman</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Ella Haker Jacob Ruff ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21222 2549 Liberty Pkwy Dundalk, Maryland Nancy Ruff (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem. 11/29/2012 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 21. Signature of Funeral Service Licensee Denni 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Du o (or as a consequence of): //Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 □ No P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð Records, page 2 should be 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 1 Yes 2 No 2 14 No 1 Yes certificate of Vital 25. Was case referred to medical Physician: 26. Place of Death (Check only one) Be examiner? 1 ✓ Yes 2 ☐ No Hospital: 1 - Inpatient Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 6 Other (Specify) မှ 28a. Date of Injury
(Month Day Year) this filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Division Director: After Injury or Attending 5 Pending investigation LOYO PM 1 ☐ Yes 2 🐧 No Chukeci on tood 11/21/12 death 2 X Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours after of Funeral Direc 4 ☐ Homicide City or Town, State) Restaurant Dundalkind 6525 Holabird AVR Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ESCOC Natuber 21 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 32. Registrar's Signature Date filed (Month, Day, State NOV 28 Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John W. Rathell 5:00 A.M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis ElderCare Hammonds Lane Baltimore Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 216 28 2293 **Director** 1 X M 2 D F 81 07/06/1931 Maryland Usual Residence of Deceder 28a-f shov filed within 72 hours after death with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 No Severn 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 1569 Redhaven Drive 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 k Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Inspector State of Maryland 10thBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o Mary Ellen Mattias should be Arthur Rathell permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mark any injury or other **** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Lambert / Daughter 309 - 16th Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery | 11/23/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 233 Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Chset and Death Physician/ Myocaro disease or condition resulting in death) Medical r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use es the burial-transi Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month 9 Unknown gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to prédical Certificate: To Be 26. Place of Deat heck onl one) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature MI)

State Registrar who completed cause of death (Item 23a) (Type Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Ε. Ratajczak Frances Nov. 7:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 220-24-9545 1 🗆 M 2🗓 F Feb. 20,1930 Maryland 27 is merked other then "naturely, or itema 23a or 28a-f ahow traumatic event, the Medical Examination at 10d. Inside City Limits 10a. State 10b Count 10c. City, Town or Location Director 1 Yes 2 No Dunda1k MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States Apt. 209 103 Center Place 21222 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours effer d
Department of Health end Mental Hyglene.
Important if flem 27 is merked other then "naturel", or it
any injury or other traumatin auch 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Day Care Day Care Provider 8 Years 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Augusta Frances Becker Andrew J. Weis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23794 Cherry Lane Lewes, DE 19958 23794 Cherry Lane Michael J. Ratajczak, Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Hilltop Service Corp. 11/28/2012 Towson, Maryland Gardner 21. Signature of Funeral Service Licensee Scott P. Buda-Ruck Fufferal Home of Dundalk, Inc. A CO 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (r as a consequence of): Examiner da Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispersion) Examine Du to (or as a consequence of): the Hoapital or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician end I for use as the burlel-tren Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Day 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 I Inknown To the Hoapital or Attending Physician: The lew requires ther within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completely filled in by the funeral director; page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific D006119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105, Touson MO 21204 St. North Charles

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 8 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 25-2012 Physician/ Catherine Reynolds 7:00p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Arundel Health and Rehab Ctr. Glen Burnie Anne Arundel . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X 76 Hours 214-32-3748 0270171936 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or h 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Halethorpe 1 Yes 2XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3900 Baltimore St. 21227 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?
1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Factory should be filed with n and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Anthony Wheeler Fairy May Zehrbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Reynolds / Son 1575 Curtis Ave., Glen Burnie, MD 21060 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 11/27/2012 Odenton, MD W. Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F Tey Funeral Home and Cremation Service, PA 23 Annapolis Rd., Halethorpe, MD 21227 M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between ENSION Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to lor as a consequence of if any leading to immedicause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown 2 No 1 Yes 2 unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autops performe death? certificate 2 No 1 🗌 Yes ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nin 24 hours after death.

the Funeral Director: After this of the funeral director in the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed Month. Day. Year (2 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MU 2104/2 0 Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 8:23 PM Regalbuto November 22, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Country) Director 86 1 M 2 D F 153-20-0968 Sep 26, 1926 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No MD Baltimore Lutherville Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Cinder Road 21093 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Custodian Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nazareno Regalbuto Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Regalbuto /Nephew 144 Westbury Road Lutherville Timonium, MD 21093 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Nov 24 4 Donation 5 Other (Specify) Beltsville, Maryland 2012 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Mar 23a. Part 1. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as \ cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-trar that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an teneend this certificate 1 Yes 2 No ☐ Yes director, a 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide eral Director: A filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral I Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cectifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only of of cert 29b. Signa ure and tith D0071287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar A Shaheen

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Cheeles

t. \$4105, Baltimore, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38186 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Geraldine A. Rutkowski 1922 Nov 2013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Union Memorial Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 218-28-9414 Director 1 □ M 2 82 01/05/1930 Maryland 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2211 W. Rogers Avenue Apt. 238 21204 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 √2 Never Married 2 ☐ Married 2 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Advertising Media Supervisor Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Albert J. Rutkowski Julia Biedronski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health Item 27 Judy Rutkowski - Niece 5064 W. Hopewell Road Center Valley, PA 18034 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If Ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 12/01/2012 Baltimore, Maryland 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility
Dayid J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 . Enter the diseas mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure Exacerbation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Twodays OPD exacerbation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (ur as a consequence of) Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year ed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier MD AT2438946 Nov. 25, 2012 1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashkan Vafadaran, 201 East University Parkway, Baltimore, MD 21218 31. Date filed (Month, Day, Year) NOV 2 8 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b-f &18 Per FH G934 12/03/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edith Hamilton Reisert November 25 2012 9:37 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital 01ney If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 241-20-8693 88 1 □ M 2 🂢 F November 16,19**2**4 South Caro. Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once. 10b. Co. 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Prince George's 01ney Maryland Silver Spring 1 ☐ Yes 2 X No 10g. Citizen of What Country? United States 10f. Zip Code 2611 Olney Sandy Spring Rd 20832 Completed by Funeral 20904 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 X Widowed 4 ☐ Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grace Iola Earge Eargle Fred Holland Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean A. Gloff/daughter 3718 John Carroll Dr. Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gard Nov. 29,2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee John O. Mitchell VIV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P.A. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pay 1. Enter the disease, or complications that caused spock, or heart failure. List only one cause on each line Immediate Cause (Final Approximate Interval Between Onset and Death Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? page 2 should be detached for Month Day Pregnant at time of death 1 Yes 2 9 Unknown 2 No g Unknown Part II. Other significant onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy perform 1 Yes 2 No Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No <u>N</u>atural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the page of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state nature a 29d. Date signe

Registrar

31. Date filed (Month, Day, Year)

NOV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 November 23° 2:15 A M Medical 4a. Facility Name (if not institution, give street and nu 4b. City, Town, or Location of Death Examiner Baltimore City Good Samaritan Hospital Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** October 1 1927 Hours 1 🙀 M 2 🗆 F Days 220-20-8525 Baltimore Maryland Yrs Director 85 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s idical Examiner must be notified Maryland Baltimore City Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 21234 USA 3305 Woodring Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ò 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3XX Widowed 4 ☐ Divorced Completed Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Oxygen Book Keeper Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Palcher Carroll T Smyth Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15804 Anthony Way Bowie, Md. 20716 Karen A Sessamen (Daughter) item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery November: 26 2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore,Maryland 21. Signature of Funeral Service/Dicensee Name and Address of Facility assahn Funeral Home Inc 22. Name and Guider and Lassahn Funeral "Höme Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. the burial-transit and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗀 No 2 A No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending Accident Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Pay, Year)
November 23, 2012 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Terrance L. Baker Scot Cuch Ruren Blud 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 28 2012

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NE DCHOULS 1010 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Harwood Mandrin Homes Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) Director 217 26 4821 1 🗆 M 2 🗓 F 81 06/29/1931 Maryland Usual Residence of Decedent show uid be filed within 72 hours after death with the Maryland Mental Hygiene. narked other than "natural", or items 23a or 28a-f shovatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Anne Arundel Linthicum Heights 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 500 Laclair Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked Elmer Jenkins Georgie Pullin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Lalair Avenue Linthicum Heights, Maryland 21090 Michael Schools / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 5 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 11/28/2012 Baltimore, Maryland any injury o Cedar Hill Cemetery 4 Donation 5 Other (Specify) 21. Signature of Foneral Service 22. Name and Address of Facility Gonce Funeral Service, Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ONA Immediate Cause (Final Onget and Death SEASE Physician/ disease or condition resulting in death) Medical Due to (or as // consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): to the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ROICE 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 24 hours after death. Funeral Director: After 1-Natural 5 Pending ☐ Accident Investigation 1 Yes 2 No Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of sertifier 29b. Sign 21438

State Registrar

DHMH 17 Rev 06-2011

Name and address of person who completed dause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

NOV 28 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day Physician/ Sandridge William C. 26 2012 12:30A Nov Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Co. Edgemere 7500 Bay Front Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) 1 XM 2 □ F Director 220-68-2241 54 Yrs Dec. 22,1957 Maryland Usual Residence of Dece 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at vice. 10b. County 10c. City, Town or Location Director Edgemere 1 🗌 Yes 2 🕱 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21219 7500 Bay Front Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Pugs Fuel Oil Business Owner 12 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Joan M. Pace Robert C. Sandridge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 257 Trappe Road Dundalk, Maryland Rachel Sandridge (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/30/2012 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☑ Other (Specify) Entombment 21. Signature of Funeral Service Licensee Dennis ²² Name and Address of Facility and Home of Dundalk, Inc. arrol. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physiclan and for use as the burial-transif Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 🗷 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No M Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ November 10:3- aM -ugene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worthwest 6. Sex 1 M 2 □ F If Under 1 Year I If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
05/16/1959 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-76-6757 Months 53 Yrs. MD Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Baltimore MD Windsor Mill 1 Yes 2 Xio 10e. Street and Number 10f, Zip Code 10q. Citizen of What Country? Funeral U.S.A. 21244 7102 Burford Ct. Apt. 103 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status or i Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 **X**No within 72 hours after Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Arc Of Baltimore Assembly Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) tth and Mental h ပ Christina White Ernest Smith Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9180 Rumsey Rd. Columbia, MD 21045 Necol Anthony (Friend) 1 and 2 s of Health a item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o once. 1X Burial 2 Cremation 3 Removal from State 11/30/12 Baltimore, MD Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) Joseph H. Brown Jr. 2140 N. Fulton Ave. 21. Signature of Funeral Service Licenses Funeral Home PA Balto., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Prunician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impory Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events physician ar resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy

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the Funeral Director: After this ce Hospital 1 Yes 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier DO071045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Jonathan 31. Date filed (Month, Day, Year) 401

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			State Registrar		Cer	tificate	e of D	eath			Reg. No.	1 E	0010
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drie	Examin		4a. Facility Name (if not institution, give s	reet and nymber)	_	4b. City,	Town, or I	Location o	of Death		4c. Count	y of Death	'
-			Riderwood Retiren	nent Communi				er Sp				ntgom	
	Funeral Director		5. Social Security Number 6. Sex 092-03-6721 Usual Residence of Decedent	7. Age (In y.	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir (Month, Da Sept •	ıy, Year)	Coun	place (State or Foreign htry) W York
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must once.		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	b. Place of Dispo	natory or o	ther place			ate -/2012	20c. Location		own, State 1e, MD
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Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	et, factory	, office		2	8f. Location (S City or Tow	Street and Numb vn, State)	er or Rural	Route Number,
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	5		30. Name and address of person who con	mpleted cause of death (I	tem 23a) (Type, F				ים ס	DINC N			,
	Stat	-	ANDREW KUNDRAT, M 31. Date filed (Month, Day, Year) NOV 2 8 201	3110 32 Registrar's Sig	GRACEFIE gnatue	ELD RI	υ., Σ) TT A E	W 251	KING, P	ш 209	-	
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Maryland 21215-0036	led within 72 hours after death with the Maryland Hygene. Other than "natural", or Items 23a or 28a-f sho ent, the Medical Examiner must be notified at	Completed	Elementary/Second	lary (0-12)	College (1-4 or 5	+)		o not us pe L	,					Utility		
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Baltimore,	it of h		20a. Method of Dispos 1 ☐ Burial 2	- Andrewson -	Removal from State	20b. Pl	ace of Dispo emetery, cre	osition (Na matory or	me of other plac	e)	[Nov 2		Location - City or	Town, Sta	ate
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£	y Phy er this eral o	e: 10	27. Manner of Death		28a. Date of inju	у	28b. Time o		28c. Injury	4 ⊔ Ni ⁄at		me_5 ∟ Hes 28d. Describe		6 Other (Specury occurred	city)	
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2	5 # E =	Certificate:	3 ☐ Suicide € 4 ☐ Homicide	6 U Could not determined		ry - At hor . (Specify)	me, farm, st	eet, facto	ry, office			28f. Location (City or To		and Number or Ru te)	ıral Route	Number,
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	he Ho in 24 I he Fu pletel	Med	(Check 2 Lonly one) 3 L	Medical Exam	niner: On the basis of ex rse Practitioner: To the	amination best of m	and/or inves y knowledge	stigation, in e, death oc	my opinio curred at t	on, death o he time, da	ccurred at te and pla	the time, date ice, and due to	and place the cau	ce, and due to the se(s) and manner a	cause(s) a as stated.	nd manner stated.
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68766

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	-	For State Registrar		010		nai yiari	-	tificate			ana n	, iornari	Reg. I	/ 11	12	38194	
Physicia Medic			mard				piro					2. Date of D Month		Day 20	Year 2012	3. Time of Death 8:24 PM	
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Funeral Director		5. Social Security Number 6. Se 131-01-5515 1 [If Under 1 Year If Under 24 Hrs. Months Days Hours Min.				8. Date of Birth (Month, Day, Year) March 31,1918			Birthplace (State or Foreign Country)		
land show dat	tor	Usual Residence 10a. State		10c. City, Town or L				ocation						1	0d. Inside City Limits		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Mari		ed 1	as Decedent med Forces' Yes 2 2 'es, Give ar or Dates.	? ☐ No		Was Deced f Yes, spec 1 Yes	ify Cubar	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	l ten		k, White,	an Indian, etc. √hite	
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Page 1 an nent of He ant: If iten iry or othe			position Cremation Documents of the contract		al from Stat	0	Place of Disponentery, cremetery, cremetery	natory or o	ther place	e)		Date +/2012	20c.	Location - Belt		own, State	
permit. Departr Importa any inju		21. Signature of Fu	uneral Sarvice H	gensee	Ma	00382	R ²	Name and	d Addres	al Facili	rd Cr	rematio ver Spr	n Se	ervice	es 209	910	
Physician/		Immediate Cause	art failure. List or (Final	nly one caus	e on each lir	ne.						or respiratory a	ırrest,			Approximate Interval Between Onset and Death	
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ne death ce y the attend iched for us	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify) 9 Unknown 1 Unknown 1 Victoria Victor										23d. Date of delivery Month Day Year					
uires that t n signed b uld be detz	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use 1											ne cause of death?				
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	cate: To	1 ☐ Yes 21 27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	th 5 🗌 Pending	1 Minpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28b. Time of injury at work? 28d. Describe how in work?)			
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ne Hospita n 24 hours ne Funera pletely fille	Medical	(Check 2	Certifying Medical Ex	caminer: On	the basis of	examination	n and/or inves	tigation, in	my opinio	n, death o	ccurred a	t the time, date	and pla	ce, and due	to the ca	use(s) and manner stated	
To the within		29b. Signature and	~ / j ~	lely	/ / /	40	ny knowledge	290	:. License	number	19			Date signed		Day, Year) 7, 2012	
15x1		30. Name and addr	ress of person w	nho complete	ed cause of	death (Item	1 23a) (Type, F	rint)	nire	, 01.	ney.	MD					
Stat Registra		31. Date filed (Mon	th, Day, Year)	2012	32 Regist	irar's Signat	ture	Med			7-						

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amend #I Per PHY G935 01/02/2013 JH
State of Maryland / Department of Health and Mental Hygiene 2 1 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 16 POLA Ricky Spain Month 6.20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL TATE HOSPICE HOUSE

5. Social Security Number 6. Sex LINTHICUM 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 11-2-1949 228-62-1063 Director 1X1M2□E VIRGINIA 63 Yrs. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD. ANNE ARUNDEL SEVERN 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1604 WOODRUFF CT 21144 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 I Hygiene. other than "natural", 1 ☐ Yes 2 ☐XNo Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) RELIGION MINISTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of 2 permit, Page 1 and 2 should be Department of Health and Meni Important: If item 27 Is marke any Injury or other traumatic once. FLORENCE SMALL LUTHER SPAIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNIE/SRAIN(WIFE) 1604 WOODRUFF CT. SEVERN, MARYLAND 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11-2^{tote}2012 1X Buria 2 ☐ gremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) REIDSVILLE, NC GARRETT GROVE U.M. CHURCH CEM. 21. Signal uneral Service Licensee JONATIAN HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Property Physician disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No မြ DILL 1 Inpatient 2 ER/Outpatient 3 DOA eral **Director:** After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of HUUSI 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o 29c. License number 0 ame and address of pe who completed cause of death (Item 23a) (Type, Print) Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ hau 1550 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Joh 105 N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, Year) Days Director 216-56-5277 1 D M 2 X F 63 11/01/1949 MD init. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 shov injury or other traumatic event, the Modesi Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 130 SLADE AVENUE, #418 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed Specify: 3 Widowed 4 X Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) TECHNICIAN RADIOLOGY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HARRY SHAW LOVEY MARGOLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRADLEY SCHOOLNICK / SON 7 GANDSON COURT, #102, LUTHERVILLE, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK: 11/27/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MEJMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Vear Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 🗡 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending the Funeral Director... 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated person who completed cause of death (Item 23a) (Type, Print) orleans

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year THOMPSON E. WILLIAM NOVEMBER 5:40 AM 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEDSTAR HARBOR HUSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 214 44 4330 1 **X** M 2 □ F 66 Maryland 05/09/1946 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2036 Pennsylvania Avenue 21227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 🕅 Widowed 4 🗆 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled 9 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Thompson Sr. Ruth Wedel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Thompson / Brother 7816 Overhill Road Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 11/26/2012 | Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature Funeral Service Part 1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final LUNG CANCER disease or condition

Physician/ Medical **Examiner**

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page 2 has

funeral director,

The law requires that the death certificate be

Hospital or Attending Physician:

within 24 hours after death. To the Funeral Director: A filled in by the

Division of Vital Records, P.O. Box 68760

Physician/

Medical

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death

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner Be Certificate:

29a. Certifier

29b. Signature and title of certifier

165, MD

VASAVADA, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- 1	regulting in death)	d.	
	resulting in death)	Due to (or as a consequence of):	
	Sequentially list conditions,	METASTATIC COLON CANCE	2
	it any, leading to immediate cause, Enter Underlying	Due to (or as a consequence of).	
	Cause (Disease or injury	C	
i	resulting in death) Last	Due to (or as a consequence of):	
		d	
3			
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	23d. Date of delivery
1	in the past 12 months?	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year
	9 Unknown	9 Unknown	
	Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
3	COPD. ESO	PHAGEAL CANCER	1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown
			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
)			performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
	25. Was case referred to medical examiner?	26. Place of Death (Ch	eck only one)
	1 ☐ Yes 2 🔀 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
	27. Manner of Death	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?	28d. Describe how injury occurred
3	1 Natural 5 Pending 2 Accident Investigation	M 1 ☐ Yes 2 ☐ No	
	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES 001

29d. Date signed (Month, Day, Year)

21

2012

NOVEMBER

HANOVER STREET, BALTIMORE, MD 21225

29c. License number

DHMH 17 Rev 06-2011

Registrar

3001 SOUTH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jeremiah Taylor, Jr. Physician/ Month 2012 9:20 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-54-2370 Director 1**X**□ M 2 □ F 02/09/1950 62 Yrs. MD permit. Page 1 and 2 should be fliad within 72 hours after death with the Maryland Department of Health and Mental Hygians. Importent: If tem 27 is merked other than "networth only injury or other treumetic average." 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5302 Bowleys Lane Apt.A 21206 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XNever Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) A&P Butcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeremiah Taylor, Sr. Eleanor Chandler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Brown (Sister) 5302 Bowleys Lane Apt.A Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus 12/3/12 Baltimore, MD ²²Name and Address of Facility Own, Jr. Funeral Home PA 2140 N. Fulton Ave. Balto., MD 21217 Signature of Funeral Service-Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician, tas TH ear resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Liqury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 42 hours after death.

To the Funseria Director Attar this cartificate has been signed by the attending physician and complistaly filled in by the funarial director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Day 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy O MAR Yes 2 No Be 25. Was case erred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 Yes 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 01-00 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier November 25, 2012 cui 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles S. 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 28 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 23, 2012 AUGUSTUS THOMPSON 10:54AM CLARENCE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Days Min 21238 8932 Director 13 06-14-1939 MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederich MD Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10q, Citizen of What Country? Funeral 201 Madison St, Apt 21701 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces?,

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Completed African Amer 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) construction Concrete other t FINISHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 Is marked of traumatic ever Department of Health and Menta Important: If item 27 is marked any injury or other transpines. Elton Thompson Flossie Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Thompson Lot 84 Frederick MD 21741 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Removal from State FairView Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12-01-12 Frederen MA . Signature of Funeral Service Licensee 110 W. South ST Gary L. Rollins Funcial Home Frederick ont to 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 2171 Immediate Cause (Final Disat and Death e DSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami To the Hospital or Attending Physician: The law lequires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of autopsy death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Propatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ☐ Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signatu DO042113 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAYEE-A BO WANY 196 TTDWY PRIECE, 1021/182 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 2 per DVR G933 11/28/12 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 3. Time of Death Physician/ Month WILLIAMS ARCHIE 5.45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Paliticent River Health Laurel rince George's Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 A Days Hours 577-68-5876 10727/ 62 Director 949 Wash DC Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Bowie 1 🗆 Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 14007 Gullivers Trail 20770 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: 3 Divorced If Yes, Give Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Archie R. Williams Sr Flore Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Williams Sister 896 Southern Ave #210 Washington D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 DOther (Specify) Atlantic Crem 11/17/12 Glen Burnie MD 22. Name and Address of Facility Simplicity Crem & Fun Serv Signature of Funeral Service Licenses none ThomasAllenPA 7090 Ridge RD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Gliona disease or condition resulting in death) Yearn Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Disk to for es a nonskoup not of cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day 5 Other (specify) Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by crebro rorrenler accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Suzure autopsy performed Yes 2 After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation within 24 hours after death To the Funeral Director, completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1516 2012 Nov.

Registrar Drivini III Rev 111008

State

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20715

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dr

14300 Gallant Fox

81. Date filed (Month, Day, Year)
NNV 2 0 2012

NOV 2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month // Physician/ 4:45 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Heritage 7232 German Hill Road Dundalk Baltimore 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6 Sex **Funeral** Min. Hours Director 218-64-4666 1 □ M 2**XX** 3/29/1924 88 PA 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE MD 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 316 OLDHAM ST. 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Yes I ☐ Yes 2 L If Yes, Give Year or Dates. 1 ☐ Yes 2 ¥ No Specify 3√Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ IRVIN BALL GERTRUDE KOELHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau AUDREY JENKINS- DAUGHTER 316 OLDHAM ST. BALTIMORE, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 TCremation 3 Removal from State ATLANTIC CREMATORY 10/26/12 GLEN BURNIE, MD 4 Donation 5 Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility SKARDA FUNERAL HOME A-01170 BALTIMORE, MD 21224 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition nges 4 4ca Medical resulting in death) Due to (or as a consequer ce of) ears Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consecu that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes}

Examiner death certificate be executed and burial-trar the attending physician Box 68760 the as 1 nse ģ P.O. signed by Division of Vital Records, peen has funeral director, page 2 certificate the Hospital or Attending Physician:

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Certificate:

Medical

show

and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at

other traumatic

and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Investigation 6 Could not be

28c. Injury at work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Excertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier rana assuale

29d. Date signed (Month, Day, Year,

Name and address of person who completed cause of death (Item 23a) (Type, Print) asswater3

31. Date filed (Month, Day, Year)

2. No

5 Pending

determined

27. Manner of Death

1 Natural

29a. Certifier

Accident

☐ Suicide ☐ Homicide Suicide

Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

within 24 hours after death.

To the Funeral Director: After this

filled in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No:-1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death 22 Day Physician/ 2012 Weisfeld 8:30 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Director 577-46-7746 1 X M 2 □ F 79 12-28-1932 Washington, DC 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, the M. stic. I.E.s. niner must be notified at 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11814 Selfridge Road 20906 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 M Yes 2 Mo Korean If Yes, Give Conflic Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Conflict 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Manager Retail should be filed v end Mental Hyg is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Isreal Misha Weisfeld Fagia Seigel 1 and 2 should be of Health end Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11814 Selfridge Road, Silver Spring, Maryland 20966 Marion Weisfeld - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Importent: If ite
eny Injury or ot 1 Durial 2 Cremation 3 Removal from State King David Mem. Gardens Falls Church, Virginia 4 Donation 5 Other (Specify) 12-26-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldber Memorial Chapels Edward Sagel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hour Immediate Cause (Final Physician/ Acute Miocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injuly that initiated events Due to (or as a consequence of): 24 hours after death.

2 hours after death.

• Funeral Director. After this certificate has been signed by the attending physician and letterly filled in by the funeral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown <u>0</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Diabetes 1 Tes 2 No 3 Probably 4 X Unknown Chronic Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Heart Failure 2 🗌 No 1 I Yes Yes 2 X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔯 No မှ 1 Inpatient 2 X ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospitai Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-22-2012 6) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Detherda, MD 20814 State 32. Registrar Signatu

DHMH 17 Rev 06-2011

Registrar

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Jels,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5900 Park Heights Ave Apt 613 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days Hours Country) Director 213-14-4384 1 □ M 2 F 08 19 20 MD 92 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho octant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examinar is ust be notified at Director 1 Yes 2 No Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 21215 Funeral 5900 Park Heights Ave Apt 613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 🏚 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Sheraton Belvedere Elementary/Secondary (0-12) College (1-4 or 5+) Waitress llth grade na Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martha Granderson Robert Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Park Heights Ave Apt 613, Baltimore 1 and 2 s of Health a item 27 i Jacqueline Dorsey-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō <u>=</u> Page 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or 2 King Memorial Park 11/30/201 Woodlawn, Md 21. Signature of Funeral Service License 22. Name and Address of Eacility
March F/H West 4300 Wabash Ave, Baltimore, Md 3a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician END-Stage (andiomyopulhe disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the luneral director, page 2 should be detached for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 5 Other (specify) P.0. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Snknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 death? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/ Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier Ms/lejapameMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21200 5203 Baltimore NSKajapaksemo 2835 Smin 31. Date filed (44) 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01:42 PM Medical 4a. Facility Name (if not institution, give street and number) Location of Death 4c. County of Death Examiner 4b. City Town, q If Under If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days (Month, Day, Year) Hours Director 1 M 2 | F 73 Jul 26, 1939 United States and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits irector 10c. City, Town or Location 1 Yes 2 No MD Baltimore ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3118 Mary Ave 21214 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married ☐ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cleaning Be Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kenneth Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Walters /Wife 3118 Mary Ave. Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of F
Important: If ite
any injury or ott Date ☐ Burial 2 Cremation 3 ☐ Removal from State Nov 23 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service License 22. Name and Address of Facility

Cremation and Funeral Alternatives MOI 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nd 21206 Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician ARDS Medical resulting in death) Due to (or as a consequence of): Examiner lardiac Ischemio Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a nunsingliander of) use as the burial-transit Cause (Disease or injury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Hospital or Attending Physician: The law requires that the death certificate be executed hours after death. Due to (or as a consequence of): C_d:f6 Colifs resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 **N**No within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical examiner? B B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 \square Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie MD AT2438946 Nov. 20,12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jaradaran Union Memorial Hospital, Baltimore, MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 28 2012

82. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b, perFH, G933, 11/28/2012, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DANIEL WILSON Month Day Year 12:49 PM Medical 24 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE VA MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Director 217-58-9266 1 X M 2 □ F 59 Jan.29,1953 MD ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> Director within 72 hours after death with the Maryland 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Perry Hall 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 4221 Chapel Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify:Black 3 Divorced 4 Divorced Completed Year or Dates. ARMY 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) N/A 12th Disabled æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hester Williams Daniel R. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Fural Route Number, City or Town, State, Zip Code, 2847 Ave. Balto, MD 212 Balto,MD 21213 Tanesha Simmons (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Garrison Forest Dec.11,2012 OwingsMills,MD 21. Signature of Funer 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 21213 Balto, Md E Preston St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ COLON CANCER disease or condition resulting in death) YEARS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing an an that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 <Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Yes 2 No 1 Yes 2 No eral Director: After this certific filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 🗷 No 1 🗷 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔀 Natural injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number D0032186 ound may M.D. 11-26-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONRAD BACTIMORE VAME, ID N. GREENE ST., BACTIMORE MD 21201 MAY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Zappardino, Sr Leonard 3:00 AM 2012 Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FutureCare Northpoint | Baltimore | Solution Baltimore Co. N/ASocial Security Number 6. Sex . Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F New York **Director** 1927 217-22-6375 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Rosedale MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7907 Riverdale Ave. 21237 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Year or Dates. WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 Years College (1-4 or 5+) <u> Automobile Mechanic/Machinist</u> Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Zappardino Pauline Puccio Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 2925 Wells Ave. Craig Zappardino (Son) Edgemere, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11/29/2012 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee Scott P. Gardner (3) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Parkinson Disco Physician/ a. advanced disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events executed Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Annexia Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the atte Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed? After this certificate 2 No 1 Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) - Shushil Sagar, MO 11/26/12 at 11:12am D0013841 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2041 Shushil Sogar, MD - 8813 Walthan Woods Rd sovile 204 Pakville, MD-21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov ^D2012 Anderson III 05:42 AM John \mathbf{C} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Ft Washington Ft Washington Medical Center 9. Birthplace (State or Foreign Country) VA 8. Date of Birth Month, Day, Mar 5, If Under 1 Year If Under 24 Hrs. Funeral Social Security Number Age (In yrs. last birthday) Days 1 M 2 🗆 F Hours 228 43 6703 Director 1973 39 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If ifew 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FORT WASHINGTON MD Prince George's 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 USA 2310 Old Gate Ct 12. Was Decedent Fiver in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Security Technician Private Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Debra Harris С Anderson, Jr John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1809 Hylton Ave Woodbridge, VA Department of Health Important: If item 27 any injury or other to Debra Anderson - mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 11/10/2012 Alexandria, VA Ivy Hill Cemetery 21. Signature of Funeral Service Licensee Greene Funeral Home, 22. Name and Address of Facility CC0234 relson Alexandria, VA 22314 814 Franklin St 23a. Part 1. Enter the disease, or com shock, or heart failure. List only tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ROIN disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, it only healing to immediate cause. Enter Underlying Examine the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) been signed by the attel should be detached for u in the past 12 months? Year Day Pregnant at time of death Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death, To the Funeral Director: After this certificate has been sign 1 Tes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examin r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F ertifying Nurs Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) certifier 29b. Signature and title 15 5m 2231 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Si State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth Elva Kathleen Arnold 3,25P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WM Regional Medical Center Allegany Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) 9/2/25 9. Birthplace (State or Foreign **Funeral** 235-32-7159 **Director** 1 □ M 2 🕮 F WV Usual Residence of Dec 28a-f show 10a. State 10c. City, Town or Location with the Maryland items 23a or 28a-f sho ler must be notified at Director 10d. Inside City Limits WV Mineral Keyser 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral New Creek Dr., PO Box 531 26726 USA death \ Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or amy injury or other traumatic event, the Medical Examinonce. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Completed 3 X Widowed 4 Divorced ^{Specify.}White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy Russell Shoemaker Bessie See 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Arnold/daughter 587-3 River Ridge Dr., Shallotte, NC 28470 20a. Method of Disposition
11 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 11/24/12 Potomac Mem. Gardens 4 Donation 5 Other (Specify) Keyser, WV 22. Name and Address of Facility Markwood Funeral Home, Signature of Funeral Service Licensee Howed N Box 912, Keyser, WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Due to (or a consequence of): disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a co requence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year detached the 9 Unknown ģ Part II. Other s<mark>ignificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Wunknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} \) 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 11/19/2012 ≥ MD 072514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willowbrook Rd Cemberland MD, 21209 12500

State Registrar 31. Date filed (Month, Day, Year) NOV 2 8 2012

amend #2066c Per FH G939 5/03/2013 III Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anthony Baione James 3 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RIGIONAL HICOMICO 544155414 Ted INSULA CPOYU If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 169-30-2699 **Director** 1 X M 2 □ F 73 04/28/1939 Pennsylvania Usual Residence of Decede permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumetic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8303 Robin Hood Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No If Yes, Give Marine Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 rt Yes, Give Year or Dates Marine 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Music Educator Public Education æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Jennie Defazio James Anthony Baione Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8303 Robin Hood Dr., Salisbury, MD 21804 Barbara Ann Baione/Spouse Place of Disposition (Nan**Gardens** Speck nghibbly ir offenory storn Shore of MD 20a. Method of Disposition 20c. Location - City or Town, State 12/14/2012 Hebron,MD 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hurlock, S Cometery 11/9/2012 | Hurlock, MD 22 Name and Address of Facility Holloway Funeral Home Professional Association Signature of Funeral Service Ucensee Snow Hill Rd., Salisbury, MD 21804 501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) una Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Fig. 2) Examine Due to (or as a consequence of). 124 hours after death.

e Funeral Director: After this certificate has been signed by the attending physicien and sletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Year Pregnant at time of death Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Apertansion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes COPO 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No æ 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title of certifier 29c. License number TC ess of person who completed cause of death (Item 23a) (Type, Print) INA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carolyn C. Carter 12:57 P M November 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Denton Caroline 104 Lou Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 217-30-9617 Director 78 1 M 2 V F Maryland Jan. 4, 1934 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner myst be notified at 10a. State 10c. City, Town or Location 10h Counts 10d. Inside City Limits Director MD Caroline Denton 1 V Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21629 104 Lou Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' Black White etc ۾ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give White 1 ☐ Yes 2 🔀 No Specify: 3

Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Easton Memorial Secretary G.E.D. <u>Hospital</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I ၉ William Harold Chance Lucy May Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale C. Williamson/ 1 and 2 s of Health Item 27 32609 Reeses Landing Rd., Cordova, MD 21625 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If Ite any Injury or ot 1 Deurial 2 Cremation 3 Removal from State Greensboro, Maryland 4 Donation 5 Other (Specify) Greensboro Cemetery 11/18/12 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.A. Pramptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 Milhael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Cerebrovas Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the attending physician and the for use as the burlal-transit or Attending Physician: The law requires that the death certificate be Box 68760 ģ Division of Vital Records, has

filed within 72 hours after death with the Maryland

pe

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi To the Hospital

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause

31. Date filed (Month, Day, Year) NOV 1 5 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lois Eunice Clark November 10, 2012 10:20P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11476 Knife Box Road Caroline Denton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Country Maryland **Funeral** 8. Date of Birth Months Days Hours Min. 2(1/19/1/19/3/7ar) 1 □ M 2 🛱 F 75 **Director** 218-34-9335 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Maryland| Caroline Denton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11476 Knife Box Road 21629 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Deceder 2.7. Armed Forces? 1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 X Widowed 4 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Homemaker Family Elementary/Seconday (0-12) College (1-4 or 5+) Estate Planning <u>Insurance salesperson</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John August Fuchs Frieda Marie Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau David Clark/son 10165 Log Cabin Rd. Denton. MD21629 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery 11/15/2012 Denton, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. si. i...n. MELANOMA disease or condition 2 YEARS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on). Examin Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and-trar Due to (or as a consequence of): burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown the hed 9 Unknow signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed?

1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4
Nursing Home 5 Residence 6 Other (Specify this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending hours after death. uneral Director: Aft ed filled in by the fur 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D39 887

Easton, MD

21601

29d. Date signed (Month, Day, Year)

11-12-2012

State Registrar

completed

within 2 To the F

29a. Certifier

(Check

31. Date filed (Month)

3 🗌

David H. Smith

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

§221 Teal Driye #301

ORIGINAL

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Capies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month July 2012 Galen Perry Corr 10:58 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Spellman House Prince Georges College Park Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) unk **Funeral** Hours 219-34-8988 **Director** 1 M 2 D F 75 Usual Residence of Decedent 03-01-1997 28a-f show 10a State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Prince Georges College Park 1 ☐ Yes 2 🔀 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4711 Berwyn House Rd. 20748 USA items 12. Was Decedent Ever in U.S. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify: 11. Marital Status unk 14. Race - American Indian, Examiner Black, White, etc. ō 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 white Specify "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation unk 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) unk unk permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other t any injury or other transmitted. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Officer Freeman - police officer 9201 Basil Ct #466; Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Sign fure Funeral Song Licenses Ade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ arrh 11 mic Cardiac Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 attending physi 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day signed by the a ld be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Jeu hus Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has ; page 2 s performed Yes 2 14 ypertennion Venons this certificate len 1 Yes 2 No 25. Was cas referred to medical examiner? director, Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Other: 2 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) funeral c 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After 5 Pending injury 1 X Natural n 24 hours after death.

le Funeral Director: At oletely filled in by the fu death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0068964 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3601 BRENTWOOD 20722 31. Date filed (Month, Day 32. Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	101	partment of Health and I		ene 9. N2 0 1 2	38213					
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death					
	Physicia Medic		Elaine Louise Dunst		November	r 11, 2012	12:50 P ^M					
A-C	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death						
			Caroline Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Denton () If Under 1 Year I If Under 24 Hrs.	8. Date of Birth	Caroline	olego (Ctato ou Foreign					
	Funeral Director		202-14-2664 1 M 2 M F 86 Yrs	Months Days Hours Min.	11/4/19	(ear) 9. Birth Cour 26	olace (State or Foreign try) Ohio					
	and show	ior	10a. State 10b. County 10c. City, Town or	Location			0d. Inside City Limits					
	Maryl 28a-f otifie	Director	Maryland Howard Woodb	ine			1 ☐ Yes 2 🖺 No					
	e filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral D	10e. Street and Number 3380 Jennings Chapel Rd.	10f. Zip Code 21797	10	g, Citizen of What Cou USA	ntry?					
	death item ner n		Armed Forces?	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,						
Baltimore, Maryland 21215-0036	ırs after ural", oı I Exami	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates.	1 ☐ Yes 2 【XNo Specify:		Specify: Whi						
15-(72 hou n "natu edica	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work	king	6b. Kind of Business In	dustry					
12	iene.	Con	Elementary/Seconday (U-12) College (1-4 or 5+)	DO NOT use retired) Iomemaker		Family						
br.	filed wall Hyg		17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma							
ylar	should be file and Mental I 7 is marked o raumatic eve	욘	Herman Lincoln Zwicker	Louise		Wolfe						
Mar	1 and 2 should be if Health and Mer item 27 is marke other traumatic			ailing Address (Street and Number or Rui			Code)					
e)	and 2 Health tem 27 other tr			N. Maple Ave. I		MD 21660 Oc. Location - City or To	own State					
TOL	permit. Page 1 and Department of Heal Important: If item 2 any injury or other ance.		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, c	rematory or other place)		Dover, Dela	·					
alti	permit. F Departm Importai any injui		21. Signature of uneral Service License	22. Name and Address of Facility		neral Home,						
<u>m</u>			rauchst terr	2 South 2nd Street								
			23a. Part 1. Enter the disease or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.			.,	Approximate Interval Between					
4	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. ALZWeimers Deneutice Onset and Death Victoria									
Jones.	Examiner		Due to (or as a consequence of):									
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or linjury									
	be executed sician and burial-transi	Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
00		lical	d									
3876	rtificat ing ph	/Mec	IF FEMALE:									
Box 68760	ath ce attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death			23d. Date of deliv Month	ery Day Year					
Ö.	the de by the ached	hysi	1 Yes 2 No 4 Pregnant at time of death > 9 Unknown									
s, P.O.	law requires that the death certificate has been signed by the attending ph ie 2 should be detached for use as th	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
ord	requi been should	lete			24a. Was an		pably 4 Unknown					
Rec	The lav ate has page 2	Completed			autopsy performe	ed? death?	mpletion of cause of					
tal	cian; certific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec			***					
Ž	Physical this caral direction	To	1 Yes 2 No 1 Inpatient 2 ER/Outpa 27. Mann of Death 28a. Date of injury 28b. Time	of 28c. Injury at		ce 6 Other (Specify)					
ou o	utending death. ctor: Afte y the fune	ficate	1 ✓ Natural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ Accident Investigation	work? M 1 Yes 2 No	28d. Describe how injury occurred							
Division of Vital Records,	0 0 0	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	Street and Number or Rural Route Number, vn, State)						
_	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or in	estigation, in my opinion, death occurred a	t the time, date and	place, and due to the ca	use(s) and manner stated.					
	To the I within 2 To the I сотрlе		only one) 3 Certifying Nurse Practioner: To the best of my knowledg 29b. Signature and title of certifier	29c. License number		d. Date signed (Month,						
7			James Jules (1)	10101	0	1-17-1	4					
			30. Name and address of person who completed cause of death (Item 23a) (Type Janes Si Des 5th Av.	e Denton	SME	2216	29					
-	Stat Registra		31. Date filed (Month, Day, Year) 32. Pecistrar's Signature	and the same of th								

DHMH 17 Rev 7/2009

1 XYes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. white 16b. Kind of Business Industry Airplanes Stigen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Chester, PA Moore Funeral Home, P.A. Denton, Maryland 21629 Approximate Onget and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) ertifier License number 3 2 0 26 29b. Signatur 29d. Date signed (Month, Day, Year) 11/1/2012 Prive Cher de MO 2/6/9 who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar **ORIGINAL**

3. Time of Death

Minnesota

10d. Inside City Limits

12:55P M

Hospital or Attending Physician: 24 hours after death. Director: / completed filled in by within 24 hours a To the Funeral C

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registra . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician/ Dykes Ethel Frances 0131 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TENINSULA REGIONAL HICOMICE Medical Cente 541156413 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Days Hours Min (Month, Day, Year) 214-30-9028 Director 1 M 2 X F 79 09/16/1933 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f sho the Medical Examiner rust be notified at the Meryland Director 1 Yes 2 X No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 1704 Eastgate Dr., Apt. 404 Pege 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. White Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Office Manager 12 of Health end Mental Hygie If Item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Frances Dykes S. Kent Dykes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31873 York Dr., Salisbury, MD 21804 Brenda R. Twilley/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State permit. Pege Depertment o Important: if any injury or ò 4 ☐ Donation 5 ☐ Other (Specify) 11/9/2012 Salisbury, MD Parsons Cemetery ^{22. Namue and Address of Facility} Home Professional Association Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ UMOTHORAX Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Entar Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami use es the burial-transit Hospital or Attending Physician: The lew requires thet the deeth certificate be executed Due to (or as a consequence of) resulting in death) Last attending physicien for use es the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregpant in the past 12 months?
1 Yes 2 No 23d. Date of delivery Ectopic pregnancy Month 5 Other (specify) cate has been signed by the page 2 should be deteched g 🗌 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting în the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy After this certificate 1 Yes 2 No 2 1 No 24 hours after death, Funeral Director: Funeral Director: After this certifica etely filled in by the funerel director, i Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours to the Funer completely file 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day David Michael Guerrero 1550 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NICIMICS REGIONAL 54436414 TENINGUE 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 230-76-9093 Director 1 🕅 M 2 🗆 F 57 10/14/1955 California 2 should be filed within 72 hours efter death with the Maryland the and Mentel Hygiene.
27 is marked other than "natural", or Items 23e or 28a-f show traumatic event, the Medical Evaritine must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Stockton Maryland Worcester 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 1419 Snow Hill Road 21864 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 XYes 2 ☐ No Specify: If Yes, Give Year or Dates army Specify: 3 Widowed 4 Divorced Completed Mexican Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Inspector/Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health end Mentel H tem 27 is marked ot ၉ Joseph M. Guerrero Martha Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1419 Snow Hill Rd., Stockton, MD 21864 Karen A. Guerrero/Spouse permit. Page 1 and Depertment of Healt Important: If Item 2: eny Injury Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 11/6/2012 Salisbury, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer disease or condition aruns 001 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam ettending physicien end for use as the burlal-transit To the Hospital or Attending Physician: The lew requires that the death certificete be executed within 24 hours efter death.

To the Funeral Director: After this certificete hes been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be detached for use as the burlal-transi. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy perform 2 No 1 Tes 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗆 No Investigation 3
Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 119 Cl. L 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19149 100 CALION 31. Date filed (Month, Day, Year) Registrar's Signat State Registrar

Box 68760 Baltimore, Maryland 21215-0036

			Pleas	se Type or Pri						jible.			
		_	For State	State of M	•	epartment of F		lental Hy	giene ₂₀	12	38217		
			Registrar 1. Decedent's Name (First, Middle, 1)	Last)	(Certificate of L	Jeatn	2. Date of Dea	Reg. No.		3. Time of Death		
	Physicia		Dorothy L.	*				Month	0.1111001				
	Medic Examin		4a. Facility Name (if not institution, g	give street and number)		4b. City, Town, o	r Location of Death	1	4c. Count	y of Death			
			Memorial Hog 5. Social Security Number			If Under 1 Year	If Under 24 Hrs.	I n Date of Rie		abot			
	Funeral Director		220 – 68 – 5931 Usual Residence of Decedent	1 □ M 2 X] F	e (In yrs. last birthdi	Months Days	Hours Min.	8. Date of Bird (Month, Day Sept.	13, 1937	Country	ace (State or Foreign y) Virginia		
	f shov	tor	10a. State 10b. County	7	10c. City, Town o	Location leralsburg		100	d. Inside City Limits				
	r 28a	Director	MD Caro	THE	rec	10f. Zip Code			10g Citizon of	1 ☒ Yes 2 ☐ No Citizen of What Country?			
	with th		312 East Centra	l Avenue			21632		United		-		
036	within 72 hours after death with the Maryland glene. er than "naturell", or itema 23a or 28a-f sho , the Medical Evaminar must be nuffled at	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc. Specify: White			
2-0	2 hour	plete	15. Decedent (Specify only highest	's Education		ecedent's Usual Occup		ina	16b. Kind of E	Business/Indu	ustry		
121	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+) lif	e. DO NOT use retired) omemaker		9	Own	Home			
land 2		0	8 17. Father's Name (First, Middle, La Robert Lee E						st, Middle, Maiden Surname) Mae Kerns				
Baltimore, Maryland 21215-0036			19a. Informant's Name/Relationship Dorothy L. Go	o (Type, Print) over/Daugl	nter 31	failing Address (Street 2 E. Cen	and Number or Run tral Ave	al Route Numbe	er, City or Town, deralsk	or Town, State, Zip Code) alsburg, MD 21632			
timore			20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	ecify)	cemetery.	isposition (Name of crematory or other place) 1. Veterans	Oem. 11/08			ck, M	Maryland		
Bal	permi Depar Impo any ir		21. Signature of Funeral Service Lic	ensee M	/.	22. Name and Address 216 N. Maj	ss of Facility Fr	amptom ederalsh	Funeral ourg, MI	Home, 21632	P.A. 2		
	executed an and inial-transit	il Examiner	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Final thorough that initiated events resulting in death) Last				Approximate Interval Between Onset and Death						
. Box 68760	Attending Physician: The law requires that the death certificate be stream. After this certificate has been signed by the attending physicic by the funeral director, page 2 should be detached for use as the bu	by Physiclan/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су			23d. Date of delivery Month Day Yea			
ls, P.O.	uires that the signed by ald be deta	ed by Pl	Part II. Other significant condition	s contributing to death	out not resulting in t	he underlying cause gi	ven in Part I.				cause of death?		
Record	The law req ate has bee page 2 sho	Completed						24a. Was autor perfo	psy prmed2		sy findings available apletion of cause of		
tal	cian: ertific ector.	Be	25. Was case referred to medical examiner?	Hospital:		The late of the same of the late of the late of	lace of Death (Chec						
Š	Physt rthis o	2	1 Yes 2 No 27. Manner of Death	1 Inpat	ient 2 ER/Outp		4 ⊔ Nursing Ho		dence 6 Oth				
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	1 Naturat 5 ☐ Pending 2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be	ury - At home, farm	ry wor			Street and Numl		Route Number,		
۵	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical ((Check 2 Medical Ex	Physician: To the best o aminer: On the basis of lurse Practitioner: To the	f my knowledge, de examination and/or fine best of my knowle	ath occurred at the time	e, date and place, a on, death occurred a	and due to the catter the time, date a	ause(s) and mar and place, and di	iner as stated ue to the caus manner as et:	J. se(s) and manner stated		
	To the vithin 2 To the comple	2	29b. Signature and title of certifier		-	29c. Licens	e number	, 200 101	29d. Date sign	ed (Month, Da	ay, Year)		
						Dog	53815		(1)	4/12			
		<		(MOO) 2	death (Item 23a) (Ty	nvestigation, in my opinidge, death occurred at 29c. Licens D 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	in ST;	EAST	on N	10 21	1601		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	bows							

12-08522 Gary Harper Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012	3821	1
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		Registrar Certificate of Death Reg. No.										
Physici		Decedent's Name (First, Midd	•					2. Date of De Month	ath Day Yea	3. Time of Death		
Medical Exam	iner	Carlo Inter						Novembe	er 10, 2012	0858 nrs		
		4a. Facility Name (if not institution Western Maryland Re	· ·	•		4b. City, Town, or I Cumberland	ocation of Dea	th	4c. County of Allegany			
Funeral Director		5. Social Security Number 215–90–2533	6. Sex 7. A	Age (In yrs. Ias 37	t birthday) Yrs	If Under 1 Year Months Days	If Under 24H Hours M		•	7) 9. Birthplace (State or Foreign Country) MD		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Locat	tion			_	10d. Inside City Lir	mits	
E	tor	MD Allega	any	Cumb	erland					1 Yes 2		
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	130 Mullen St.				10f. Zip Code 21 502			10g. Citizen of Wr	•		
r death or ite	by Funeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div	arried 12. Was Decede Armed Force 1 Yes Orced If Yes, Giva Year or Dates:		. 13. Walth	as Decedent of Hisp es, specify Cuban, Yes 2 No	Mexican, Puer	Specify Yes or N to Rican, etc.)	White	- American Indian, Black, a, etc. White		
2 hours afte "natural", Examiner		15. Decedent's Education (Spe	cify only highest grade c	ompleted)		nt's Usual Occupati			16b. Kind of Bu	siness/Industry	_	
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural!", e event, the Meileral Examines	Completed	Elementary/Secondary (0-12)	College (1-4 c	or 5+)	•	isabled	DO NOT use re	etired)	Nor	ne		
5-0 iled w Hygie		17. Father's Name (First, Middle, Gary D. Harper	Last)			l l			Maiden Surname			
21215-00 ould be filed with 1 Mental Hygiene 1 marked other i	Be							(Lucas)				
nore, MD 2121 ages 1 and 2 should be fi nt of Health and Mental tt: If item 27 is marked other traumatic event,	To	19a. Informant's Name/Relations Carole Harper/Moth	t Cumber:	Rural Route Nu land MD 21		n, State, Zip Code)						
Baltimore, permit. Pages I an Department of Hea Important: If iter		20a. Method of Disposition 1 Surial 2 Cremation	State cre	ematory or ot			Date	20c. Location -	City or Town, State			
Baltimo permit. Page. Department o Important: injury or oth		4 Donation 5 Other St. 21. Signature of Funeral Service		Fro		Memorial Par		/13/12				
Perm Depu		1500			\$0 10	Name and Address arpelli Fun 8 Virginia	eral Home Ave Cumb	P.A. Erland MD	21502			
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Between Onset a		
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1	Ē	Sequentially list conditions, if any, leading to immediate	b	nsequence of):								
A. S.	Examiner	cause. Enter Underlying Cause (Discass or injury that imitiated events resulting in death) Last	c. Due to (or as a cor									
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760, icate be execut physician and the burial - tran	ğ	X UNPENDED	AMENDED 16 23a,pt.II	,27,28a	in, g93 i-f, pe :	3 11-28-1 r me,g933	11-29-	-12 sm				
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Box 68 e death certi the attendin ed for use a	Physician	1 Yes 2 No 9 Unk	(nown 9 Unknown		□ 0t	her (Specify)					- 1	
P.O. Bes that the digned by the detached	ğ	Part ii. Other significant condit				underlying cause gi	ven in Part I.			ibute to the cause of death? Probably 4 Unknow		
ds, equire een sig ould b	Completed	<u>Hypertensive</u>	Cardiovasco	ular pi	sease			24a. Was		Vere autopsy findings availa		
of Vital Records, g. Physician: The law require there this certificate has been si neral director, page 2 should b	ם							auto perfe	psy p	prior to completion of cause of leath?		
tal Rection: The certificate ector, page		25. Was case referred to medica				00 Plans	- (D + / O	1 ✔ Yes	2 No 1	Yes 2 No	Ш	
/ital siciar is cert	Be	examiner?	Literative to	tient 2 🗸 E	R/Outpatient		of Death (Check other 1 Nurs		Residence 6	Other:	-	
of \graphs	5	1 Yes 2 No 27. Manner of Death	28a. Date of Ir (Month, Day		28b. Time of I		at Work?		how injury occum		-	
Division tal or Attendin rs after death.	Certification:	Natural 5 Pend Pend Invest	ing stigation fd 11-	10-12	fd 08:	5 am	es 2 X No			edication		
Divi	ertifi		d not be	Fd: Home		et, factory, office bu	ilding, etc.	or Town,	(Street end Numbe State) 130 Mi 1and, MD.	er or Rural Route Number, C Llton St.	ity	
Division of Vital Records, P.C. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Medical C	29a. Certifier (Check only one) 2 Medical Example 1	nysician: To the best of miner:On the basis of ex	kamination and	, death occur	red at the time, dat tion, in my opinion,	e and place, ar death occurred	nd due to the cau	ise(s) and manner	as stated. ue to the cause(s)		
To wit	Mec	29b. Signature end title of certifie	and manner state	d		29c. License				ed (Month, Day, Year)	\dashv	
		Carol	Halla	an		O.C.N	I.E.		November			
		30. Name and address of person Carol H. Allan, MD	who completed cause of Assistant Medical		,	Baltimore Stree	et, Baltimore	e, MD 21223				
St Regist		31. Date filed (Month, Day, Year) NOV 2 8 2012	32. Regist	rar's Signature	arked							
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 31 20^{Tear}2 P^{M} 9:10 Physician/ Regina Lee Murphy Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Queen Ann Centreville Hospice of Queen Ann g. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number (Month, Day, Year) Baltimore Hours **Funeral** Months Days 1 □ M 2 □ XF 58 1954 Director 219-60-1238 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State must be notified at Director 1 X Yes 2 🗆 No Hillsborough Lutz Florida 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò Completed by Funeral USA 23a 33549 15105 N. 19th St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or itel injury or other traumatic event, the Medical Examiner Armed Force 1 Never Married 2 Married Yes 2 💢 No Specify: White 1 ☐ Yes 2 🔀 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give 3XXWidowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Automotive Accountant 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Innportant: If item 27 is marked of any injury or other traumatic everones. Elizabeth Constance Poist ၉ Robert Earl Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12635 Ridgely Rd., Greensboro, Md. Brother Guy Murphy 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State Chesapeake Creamation Nov 2,2012 Chester, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityFleegle & Helfenbein Fun. Hm. 21. Signature of Funeral Service Licensee 106 W. Sunset Ave, Greensboro, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CANCER Physician/ disease or condition resulting in death) UTERINE Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical I attending physician Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death IF FFMALE: 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month Day Year in the past 12 months? Other (specify) g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown eral Director; After this certificate has been sign filled in by the funeral director, page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospue 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Yes ၉ 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: injury 5 Pending 1 Natural 2 🗌 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be determined 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title

31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 & 2012

2540

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. DILEA

DHMH 17 Rev 7/2009

3

Centreville

29c. License number

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Martin Hattie Gay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner REGIDIOL MEDICAL HICOMICO SA 4/364/4 Centu If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Numbe Birthplace (State or Foreign Country) Days Director 227-24-0697 1 🗆 M 2 🗓 F 03/07/1921 Virginia and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Virginia Accomack Saxis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23427 USA 8363 Charles Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes. Give 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arenthia Linton James Hathaway Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dixie Wells/Daughter 109 Graham Ave., Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Downing's Cemetery 11/8/2012 Oak Hall, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thornton Funeral Home 24183 Chadbourne Parksley, VA 23421 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death confeeting the feeting. Immediate Cause (Final Severe Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 8xtells in Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Atherosclering attending physician and I for use as the burial-transit monare Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ perferma Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu d, title of dentifier P25036

State

Registrar
DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HORE SALISBURY, M.D.

. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registraramended item#9/19-wchd-te-11 Ceptificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Arthur Month Day Leroy Merritt 7:45 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL MORICAL SALISBURY NICIMICO If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 16-38-9011 Days Director 1X M 2 | F 71 Usual Residence of Deceder 03/10/1941 Maryland ir than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5746 Rip-Wil Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married \$ 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 hours after 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 a 1 and 2 should ba filad wit of Health and Mantal Hygle If item 27 is marked othar r Envioromentalist Marcor Environmental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Paga 1 and 2 should ba Department of Health and Mant Important: if Item 27 is marke, any injury or other traumatic e once. Avery Merritt Mary Culp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty June Merritt/Spouse 5746 Rip-Wil Dr., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 11/5/2012 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Stewart Funeral Home by Holloway and Downey, P.A. Kell R CER 821 West Rd., Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) De المما Medical Due to (or as a consequence of): Examiner Bactem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Decubitus ulce the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): ad by the attanding physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month 1 ☐ Yes ∠ ∟ 9 ☐ Unknown 9 Unknown n signad by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been significate has been significated and director, page 2 should 1 Yes 2 No 3 Probably 4 Unknown Enl Stage COPA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 DAN 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 88 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes Other: 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hoepital or Attanding Phy within 24 hours after death.

To the Funaral Director: After this completely filled in by the funeral or 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hoepital or Attanding | 24 hours after daath, 1 Matural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 140056197 TO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salish 10815 e, Carroll 31. Date filed (Month, Day, Year) State NOV 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LEE OUTTEN 0150 M 201Z Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NICIAICO REGIONAL Certer 346156414 HIHSULA ocial Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 214 60 9786 1 X M 2 - F MARYLAND 1952 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director GIRDLETREE 1 XYes 2 No MARYLAND WORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3317 SNOW 21829 USA HILL 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 1 and 2 should be filed within 72 hours aft f Health and Mental Hygiene. Item 27 is marked other than "natural", If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 TH GRADE CONSTRUCTION TRUCK DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ ARTHUR LEE OUTTEN SWIFT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GIRDLETREE, CINDY 3317 SNOW HILL RD OUTTEN WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATERIUM NOU 07 2012 CHINCOTERGUE, VIRGINIO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FOX FUNERAL HOME 10 BOX 278 Alton TEMPERANCEVILLE, VIRGINIA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ associated Health care Dueumoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner uadripleaid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 ☑ No 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death. To the Funeral Director: After this certifies 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) 2 🐼 No Certificate: To 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 73705 11,6,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ISHA 100 E. CARROLL ST. SAlisbury 31. Date filed (Month

DHMH 17 Rev 06-2011

Registrar

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dorothy Ann Parsons 06 Žear 2012 2:08 AM M Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death ${\tt Marydel}$ **Examiner** 4c County of Death Caroline 18131 Henderson Rd. 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛣 F 213-32-8004 79 **Director** 11,1933 Sept. Usual Residence of Decedent 28a-f show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Caroline Marydel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21649 18131 Henderson Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ☒ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Rae Louise Pennington Henry Joseph LaQue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Delp 16868 Haritage Hills Ln. Henderson, MD, 21640 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth once. 20c. Location - City or Town, State

 X
 Burial
 2
 ☐ Cremation
 3
 ☐ Removal from State

 ☐ Donation
 5
 ☐ Other (Specify)

 cemetery, crematory or other place) Eastern Shr. 11/09/2012 Hurlock, MD 22. Name and Address of Facility 106 W. Sunset Ave. Greensboro, MD, 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition DEWENIZA Medical resulting in death) Examiner NERTLIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit HRONI/ that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be UBSTRUCTION HRONTO P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🛣 No Month Dav Year been signed by the should be detached 1 ☐ Yes ∠
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, HYPERTENSIOU 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has BOPOROSIS performe 1 🗌 Yes 2 🌉 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 📆 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

onth, Dey, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Znic 4.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11Leon Anthony Rhodes 9 409M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13590 Holly Rd. Greensboro Caroline Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 □ F Country)
Maryland 90 Months Days Hours (Month, Day Year 216-18-8180 Director 05 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Caroline <u>Greensboro</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13590 Holly Road 21639 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 X Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 L<u>ab Technician</u> Pet Milk e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Norman Leon Rhodes permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Laura Stella Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine E. Rhodes 13590 Holly Rd., Greensboro, Md, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery Nov. 6,2012 Greensboro, MD Signature of June al Service Licensee 22. Name and Address of Facility Fleegle & Helfenbein Fun. Hm. 106 W. Sunset Ave., Greensboro, MD, 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ KINO disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 🗌 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy 2 1 No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 27, Manner Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 29b. Signature and title 29d. Date sign

State Registrar 30. Name and address of person 📢

31. Date filed (Mo

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pleted cause of death (Item 23a) (Type, Print

2. Registrar's Sign

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	State of Maryland / Department of Health and Mental Hygiene 2012 3822											
		Registrar 1. Decedent's Name (First, Middle, Last)		C	Certificate of L	<i>Death</i>	2 [Re Date of Death	g, No.	1 hom	3. Time of Death	
Physicia Medic		Robert Marshall Rich	nards	on			1.1	wonth	r Day	Year ZCIZ		
Examin		4a. Facility Name (if not institution, give street and number, MEMORIA) HOSPI			4b. City, Town, o	r Location of			4c. County	of Death	+	
Funeral Director		5. Social Security Number 218−16−9181 Usual Residence of Decedent 6. Sex 1X M 2 □ F	Age (In yrs. Ia	ast birthda 7 Yrs	Months Days	If Under 24 Hours	Min. (#	Date of Birth Month, Day, Y	^(ear) ,1924	Coul	Birthplace (State or Foreign Country) Maryland	
aryland a-f show ffied at	Director	10a. State 10b. County MD Caroline	10c. City	y, Town or	Location Federals	burg	/		•		10d. Inside City Limits 1 X Yes 2 □ No	
ith the M 23a or 28 st be not	ral Dir	109 Fisher Avenue			10f. Zip Code	21632			g. Citizen of V			
eath w tems?	Funeral	11. Marital Status 12. Was Deceden		S. 1	Was Decedent of H If Yes, specify Cuba		n? (Specify Y				can Indian,	
idilid Z 1Z 13-UU30 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates.	[?] No ¹42 −		If Yes, specify Cuba 1 ☐ Yes 2X No		Puerto Rican	ı, etc.)	Specify:	k, White,	white	
"natu	Completed	15. Decedent's Education (Specify only highest grade completed)		(G	cedent's Usual Occup	ation during most o	of working	1	6b. Kind of Bu	usiness/Ir	ndustry	
within giene.		Elementary/Secondary (0-12) College (1-4 o	r 5+)		e. DO NOT use retired) er Service	Techn:	ician		E.I.	DuPo	ont Co.	
I the first standard in the Maryland of the Maryland of the stand Mental Hygiene. The earth and Mental Hygiene. The earth and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) William Ralph Richardson, Sr. 18. Mother's Name (First, Middle, Maiden Surname Vera MacDonald								e)		
d 2 shouf atth and 1 27 is m er trauma	8	19a. Informant's Name/Relationship (Type, Print) Glenna L. Richardson	/Spous		alling Address (Street a							
permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traumatic event, the Meone.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from Start Uponation 5 □ Other (Specify)		emetery o	sposition (Name of crematory or other place est Cemeter	e) 1	Date 1/06/1		oc. Location - rederal		own, State	
permit. Departiment Import any inj		21. Signature of Funeral Service Licensee	/		22. Name and Addres	ss of Facility .	Frampt Federa	om Fui Isburg,	neral H MD 2163	Home, 2	P.A.	
Physician/	0 0	23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	ed the death ne.		enter the mode of dyin	g, such as ca	ardiac or resp	piratory arrest	3		Approximate Interval Between Onset and Death	
Medical Examiner		resulting in death) Out to (or as	s a consequ		,							
rfed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequ	ലരം ഗു.								
rate be executed physician and the burial-transit	_	that initiated events resulting in death) Last										
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To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	Medical	29a. Certifier 1 Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practitioner: To the basis of only one) Certifying Nurse Practitioner: To the basis of only one)	examination	and/or inv	estigation, in my opinio	n, death occu	urred at the tir	ne, date and p	place, and due	to the ca	use(s) and manner stated.	
To t with To t		29b. Signature and title of certifier	6	45	29c. License	number PYO	43	290 1	I. Date signed	(Month,	Day, Year) 2, 2012	
		30. Name and address of person who completed cause of PHUL W. MOVITY W	death (Item	23a) (Type 9 5,	e, Print)	fr5+.	EA.	Ston,	N	2/0	601	
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Division of Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral D

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 7151132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jorge H Abrego, 598 Cynwood Dr., Easton, MD, 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

Registrar

State

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 2326 William Vaughn Schultheis 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lalbot Easton Memorial Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 212-28-7580 82 1 ፟M 2 □ F Director 10/13/1930 Maryland Usual Residence of Decedent permit. Pege 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelih and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumetic event, the Madical Evantinet must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 ☐ No Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 462 Dutchmans Lane 21639 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 X Married Schultheis Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Schultheis Margaret Audrey Downey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Dechaine (daughter) 25670 Hill Rd. Greensboro, MD, 21639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel Cem. 11/12/2012 Rock Hall, MD 21. Sign were of Foural Service License 22. Name and Address of Facility 106 West Sunset Ave. Greensboro, MD, 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition 2724 Medical resulting in death) Due to (or as a consequ Examiner una Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of To the Hospitel or Attending Physicien: The lew requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 ANo 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Auc w. Monte ms 219 31. Date filed (Month, Day, Year) NOV 0 8 2012 32. Registrar's Signature State Registrar

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DHMH 17 Rev 06-2011

Physician /Medical Examiner

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To the Funeral Director:
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Department of Important: If its any Injury or o

Examiner must be notified at

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No ş Completed 25. Was case referred to medical Be Но ပ္ 1 Yes 2 No 27. Manner of Death Certification: 1. Naturai 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

		24a. Was an autopsy performed? 1∐ Yes 2 Ko	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🌠 No
	26. Place of Death (C	Check only one)	·
spital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	5 ☐ Residence 6	☐Other (Specify)
(Month, Day Year) Injury	Injury at Work? 1 ☐ Yes 2 ☐ No	f. Describe how injury	occurred
28e. Place of injury - At home, farm, street, factory, off building, etc. (Specify)	fice 28f.	. Location (Street and City or Town, State)	Number or Rural Route Number,
cian: To the best of my knowledge, death occurred at the	he time, date and place, and	d due to the cause(s)	and manner as stated.

29b. Signature and title of certific

(Check only one)

1 Certifying Physic

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print) ess of person who

LINBOUN n MO 32 32. Registrar's Signature (300MINGDA 31. Date filed (Month, Day, Year)

State Registrar

Medical

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Year Physician/ 10360 M DALE THORNTON WAYNE November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBULU VICONICO TENINSULA REGIONAL Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months Min. 222 66 4550 Director 1 X M 2 🗆 F 53 VIRGINIA TUNE 29 Show 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho Director 1 Yes 2 M No TEMPERANCEVILLE VIRGINIA ACCOMACK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23442 SAXIS ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 TH GRADE MECHANIC AUTO REPAIR t. Paga 1 and 2 should ba filed with thant of Haalth and Mental Hyglantant: If item 27 is markad other 1 jury or other traumatic event, In Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, GARLAND JAMES BEVERLY RUTH DELMAS THORNTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 SAXIS TEMPERANCEVILLE UA 23442 SUSAN ELIZABETH THORNTON WIFE ROAD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Paga 1 Dapartmant of important: if it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NOV 09 2012 OAK HALL DOWNINGS CEMETERY VIRGINIA 22. Name and Address of Facility FUX FUNERAL INCME PC BCX 278 21. Signature of Funeral Service Licensee 23442 TEMPERANCEVILLE VIRGINIA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ENTRICULAR ease or condition Medical resulting in death) Due to (or as a consequence of): 104RS Examiner ISCHEMIC 5-quaritiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ATHEROSELEROSIS burial-transit Exam (1020NA Hospital or Attenting Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending representations within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician of the Funeral Director: After this cartificate has been signed by the funeral director, page 2 should be detached for use as the burlation of the funeral director. Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day ☐ Yes 2 ☐ No a
Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TAILURE 2 ☐ No 3 ☐ Probably 4 🛍 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မှ 1 🗡 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Coffner 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioners to the best of my knowledge, death occurred at the time, date and plane, and due to the causelet and manner as state suly one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE SAUSBURY SIMMANUEL 400 E. SHORE NCKH

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year), NOV 07

Registrar's Signa

	-	Pleas	e Type or Pri State of Ma		d / Depa	artment of I	Health and			gible.			
Physicia: Medic		Registrar 1. Decedent's Name (First, Middle, L. Anthony	ast)	Tra	pane	tificate of I	Death	2. Date of Do	eath Pay,	0 2 2012	3. Time of Death 0		
Examine	er	4a. Facility Name (if not institution, given 125 Copper Oal				4b. City, Town, o Woodsb	r Location of Deat	h	4c, Coun Fred	ty of Death Ierick			
Funeral Director				e (In yrs. Ia 42	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, D	rth ay, <i>Year)</i> B, 1970	Coun	olace (State or Foreign try) fornia		
vith the Maryland 23e or 28e-f show	irector	10a. State 10b. County Maryland Freder	ick		Town or Loc odsbor					1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No		
h with the ns 23e or nuet be	neral D	10e. Street and Number 125 Copper Oak	s Court			10f. Zip Code 21	798			Og. Citizen of What Country?			
filed within 72 hours efter deeth with the Maryland al Hygiene. d other then "neturel", or Items 23e or 28e-f sho event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates.	ver in U.S No	11	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 ☐ XNo	an, Mexican, Puer	pecify Yes or No to Rican, etc.)	BI	ace - Americ ack, White, of fy: Whit	etc.		
permit. Page 1 and 2 should be filed within 72 hours eft Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", ery injury or other treumetic event, the Medical Exa once.	Comple	15. Decedent's (Specify only highest s Elementary/Secondary (0-12) 12		i+)	(Give I life. D	lent's Usual Occup kind of work done D NOT use retired) 'e Giver	during most of wo	rking		Business/Industry th Care			
id be filed v Mental Hyg arked othe etic event,	To Be	17. Father's Name (First, Middle, Last Richard James	ſ	3. Mother's Name (First, Middle, Maiden Surname) Joanne Monroe									
and 2 shou Health and em 27 ls m ther treum		19a. Informant's Name/Relationship Kathryn V. Lamm	State, Zip 0										
nit. Page 1. artment of 1 ortent: If its injury or or or 2.		20a. Method of Disposition Date 20c. Location - City or Town, State											
permi Depa Impo eny is		21. Signature of Funeral Service Liberatee MO0255 MO0255 As and Address of Facility and Bastford PA Funeral Home 106 East Church St., Frederick, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Physician/ Medical		23a. Part 1. Errier the disease, or co- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	the death	ence of):	nal Fo Nellihu	re luce	or respiratory a	rrest,	_	Approximate Interval Between Onset and Death		
*Examiner	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to for as a	abel	acousty	Nellipe							
9 F E	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су			Date of deliver	ery Day Year		
ires that the signed by ld be deta	d by P	Part II. Other significant conditions	contributing to death b		ulting in the u		ven in Part I.		,		e cause of death?		
The lew requate has been page 2 shou	Complete	Peripheral.	neviopall	ly				24a. Was auto perf	an 24b	. Were autop	osy findings available inpletion of cause of		
ysiclan: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 I	ER/Outpatien	Oth	lace of Death (Che						
ttending Ph death. stor: After th y the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	28a. Date of injur (Month, Day	ry v, Year)	28b. Time of injury	28c. Injur worl	y at	28d. Describe	how injury occu	rred			
spital or A ours after leral Direc		4 ☐ Homicide determine 29a, Certifier 1 ☐ Certifying Ph	building, etc	. (Specify)			o data and place	City or To					
To the Hos within 24 h To the Fun completely	Medical	(Check 2 Medical Exal	miner: On the basis of exercitioner: To the	xamination	and/or invest	igation, in my opini	on, death occurred the time, data and	at the time date	and place, and d	lue to the cau	ise(s) and manner stated.		
N		30. Name and address of person who	completed cause of di	eath (Item		nint)	05463	4	Novem	ber 20	2012		
State		Or Sucd W A 31. Date filed (Month, Day, Year)	la Gue	00 ur's Signatu	Mon	tclair	e Ave.	Fre	deri	ck,1	nd,21701		
Registra	_	NOV 2 8 201	2 Dener	ß.	gar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thomas Ray Williamson 1918 M November 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Memorial Hospital Easton Ta 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 213-42-0086 1X M 2 □ F 69 Maryland Yrs Aug. 27, 1943 or then "neturel", or items 23a or 28e∙f show the Medical Examiter must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Caroline Federalsburg 1 Tes 2 No 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral 21632 6912 Dion Road United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ₹ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 61-64 White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leon Williamson Louise Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6912 Dion Road, Federalsburg, MD 21632 Marie J. Williamson/Spouse Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Removal from State cemetery, crematory or other place) 11/11/12 Federalsburg, Maryland Concord Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ · latera Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and ched for use es the burial-trens? Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by oun runerel Director: After this certificate has been si completely filled in by the funeral director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Thinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 Yes 2 No Hospital or Attending Physicien: 24 hours after death.
 Funerel Director: After this certifica 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Departient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tyes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death only one 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State

Registrar

2195

Washington

taston.

Name and address of person who completed cause of death (Item 23a) (Type, Print) Shields

32. Registrar's

31. Date filed (Month, Day, Year)

NOV 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Phillips Wright 2012 bctober 4:20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico Social Security Number If Under 1 Year I If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 217-14-8899 1 **№** M 2 🗆 F 91 09/19/1921 Delaware 28a-f shov 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 23a USA 1006 Riverside Drive 21801 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Manager Animal Feed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ should be Denala Phillips Thomas Wright permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 462, Hebron, MD 21830 Phil Wright/Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Speglfy) 11/5/2012 Wicomico Memorial Park Salisbury, MD of Funeral Ser Holloway Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch line. 1. Enter the disease, or complications that Approximate Interval Between Onset and Death hock, or heart failure. List only e cause on e Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): signed by the attending physician and I be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown completely filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed? Yes 2 2 No 1 Yes To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifica Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဍ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 1 Tyes 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date

Registrar

P.O. Box 68760

Records,

Division of Vital

916

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Alexander, Harvey

9	PI
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene														
		-	_ State	State of Ma	aryland	•	artment of F <i>rtificate of L</i>			0010	38234				
			Registrar 1. Decedent's Name (First, Middle, Last)				tillicate of L	Jeaur	2. Date of Dea	Reg. No.	3. Time of Death				
П	Physicia		Harvey George Alexar	nder III					Month	23 2012	3:05 PM				
and the	Medic Examin		4a. Facility Name (if not institution, give stree	et and number)			4b. City, Town, or	Location of Death	4c. County of Dea						
-do	-		Franklin Squai	e HOSP	rita.		Rosec	Rosedale Baltimore							
1	Funeral Director		5. Social Security Number 6. Sex 212-32-5747	7. Age	, ,	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) Co	rthplace (State or Foreign buntry)				
			Usual Residence of Decedent		77	Yrs.			repruary	y 10,1935	Maryland				
	yland f sho ed at	tor	10a. State 10b. County		-	Town or Lo					10d. Inside City Limits				
	e Mar r 28a- notifi	Director	Maryland Baltimore 10e. Street and Number	3	Dali	CTINOLE	10f. Zip Code			10g. Citizen of What C	1 Yes 2 No				
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ral	1113 Regester Ave.				212	39			ited States				
	tems er mu	Funeral		Was Decedent E Armed Forces?	ver in U.S	. 13.	Was Decedent of H	ispanic Origin? (Spanic Origin? (Spanic Origin?)	ecify Yes or No-	14. Race - Am					
36	after of	by	1 Never Married 2 Married	1 Yes 2 X	No	ŀ	1 Yes 2 X No		Thour, oto.	Black, Whi Specify:	white				
00	atura cal Ex	Completed	3 Widowed 4 X Divorced 15. Decedent's Educa	Year or Dates.		16a. Dece	dent's Usual Occup	ation		16b. Kind of Business					
215	n 72 h an "n Medi	mpl	(Specify only highest grade of	ompleted)	+)	(Give		during most of work	ing	TOD. TAILE OF BUSINESS	, in educati				
21	/giene /giene rer th t, the										Lon				
and	be filed ental Hy ked oth ic event	To Be								^{Maiden Surname)} rine Johanı					
Z	should be filed with n and Mental Hygier 7 is marked other tranmatic event, th		19a. Informant's Name/Relationship (Type,			10h Maili	ng Address (Street								
Baltimore, Maryland 21215-0036	d 2 sh alth ar 27 is ir trau	ĺ	Ethel Vickery/siste		., Apt. B	n, NJ 07856									
ore,	of Hear of Hear fitem	20a. Method of Disposition 1 □ Burial 2 🔀 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)							Date	20c. Location - City o	r Town, State				
ţim	mit. Page partment o sortant; If / injury or		4 Donation 5 Other (Specify)	novai iroin state		ro Cre	ematory	Nov.		Baltimore					
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	1 X		M	ttchell-w	redereld	Funeral	Home, Inc MD 21212					
			23a. Pag 1. Enter the disease, or complica	tions that caused	the death						Approximate				
	Phylician/	8 8	sylock, or heart failure. List only one commediate Cause (Final disease or condition	D	one		Edn	20			Interval Between Onset and Death				
	Medical Examiner		resulting in death)	Due to (or as a				1100							
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	executed an and rial-transit	Exa	that initiated events c resulting in death) Last	Due to (or as a	consequ	ence of):									
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687	ertifica ding p se as 1	/Me	IF FEMALE:	If yes, outcome	of pregnar	ncv				23d. Date of d	ali an				
Box 68760	atten atten	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant a	2 🗌 Fetal	death 3	Ectopic pregnandOther (specify)	су		Month	Day Year				
O. E	s that the death certi igned by the attendin be detached for use	Physician/Medica	9 🗌 Unknown	9 Unknown 9 Unknown											
, P.O.	es that signed I be de	by	Part II. Other significant conditions contri	outing to death b	ut not resi	ulting in the	underlying cause gi	ven in Part I.		bacco use contribute t	Probably 4 Nonknown				
rds	requires been sig should b	etec							24a. Was a		utopsy findings available				
ecc	sician: The law r certificate has b lirector, page 2 s	Completed							autop perfor	prior to death?	completion of cause of				
a R	ysician: The la is certificate ha director, page	Be Co	25. Was case referred to medical				26. P	lace of Death (Chec	1 Yes	2 M No 1 L Ye	es 2 🗆 No				
Zit.	ysici	To B	examiner? 1 Yes 2 No	oital: 1 🔲 Inpatie	ent 2 🖭	ER/Outpatie	ent 3 DOA Oth	er: 4 Nursing H	ome 5 🗆 Resid	lence 6 Other (Spe	ecify)				
ı of	ding Phys h. After this funeral d		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of inju (Month, Day		28b. Time o injury	worl	k?	28d. Describe h	ow injury occurred					
Sior	Attenc death ctor: ,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ıry - At ho	me, farm, st	M 1 ∟ reet, factory, office	Yes 2 □ No	28f. Location (S	treet and Number or R	ural Route Number,				
Division of Vital Records,	tal or / s after al Dire ed in b		4 Homicide determined	building, etc	: (Specify))			City or Tow	n, State)					
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	edical	29a. Certifier 1 Certifying Physicia 2 Medical Examiner:	n: To the best of On the basis of e	my knowle	edge, death and/or inve	occurred at the tim stigation, in my opini	e, date and place, a on, death occurred a	and due to the ca at the time, date a	use(s) and manner as and place, and due to the	stated. e cause(s) and manner stated.				
	o the l	Me	only one) 3 Certifying Nurse P 29b. Signature and title of certifier	ractitioner: To the	e best of m	ny knowledge	e, death occurred at 29c. Licens			he cause(s) and manner 29d. Date signed (Mon					
5	N 52							0 7832			,23 2012				
	10/1		30. Name and address of person who comp				Print)				, , , , , , , , , , , , , , , , , , , ,				
	V C		Dr. AZher Merch	20 + 90	00 Fr	ankli	n Square	Drive B	altim	ore mp	21237				
	Stat Registra	ar	31. Date 1100 W 2" 9" 2012 A.	32. Registr	. 1	arke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #30 ner dyr, 9933 11-29-12 sm

State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 25 2012 12:29PM JONATHAN N ALFORD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 155 56 1318 Director 1 M M 2 □ F 01-17-1959 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaminer must be notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick 1 XYes 2 ☐ No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral US AVE, Apt 13 21701 Motter 1313 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Rlack Completed 3 DWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry should be filed withIn 72 th h and Mentel Hygiene. 7 Is marked other than "n during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications ATTT Technician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Alford Nathaniel Olivia Horsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Butteroup NJ 08046 Alford Willingbord Olivia mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Linden, NJ Rosedale Cemeteri 12-03-2017 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensed 110 W South St PO BOX3 500 22. Name and Address of Facility Jan Gary L Rollins FuneralHome Frederick MD 21705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition set and Death Physician/ Due to (or as a consequence of): Medical resulting in death) [‡]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires their the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed'; 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 51610 \mathcal{M} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Tolino 7715 Guilford Dr. Ste: 202 Frederick, MD, 21704 31. Date filed (Month, Day, Year) NOV 2 9 2012 32. Registraris Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 20/ 2 BRAILEY :30 PM 14-1AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOUBER REHABILITATION CENTER) PRING RCOLA HEALTH AND ILVER -8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 ★M 2 ☐ F Hours Country) NIA 227-30-6539 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 No Yes 2 □ No 'CASHINGTON 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20012 USA WALNUT TREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married Yes þ 2 🗌 Baltimore, Maryland 21215-0036 If Yes, Give 1949-1953 Year or Dates. 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) GOVERNMENT TECHNICIAN Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) NASHINGTON DC 20612 STREETNO EWERLEAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State VANTICO NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 11-30-2012 PRIANGLE VIRGINIA STRVICE LCC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Armocht FUNERAL M01251 20011 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseq.) Examiner Securatially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, 29b. Signature and title 29c. License number

State Registrar 30. Name and address of po

31. Date filed (Month, Day, Year) NOV 2 9

DE. AHHED HESHHAT

2401 RESORVCH BUYD ROCKULLE, MO

20850

rson who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 9 A^M Ellen 2012 2:33 J. Brinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3800 Enfield Chase Court #120 Prince George's Bowie Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Day, 1 - M 2 X F Hours Director Pennsylvania 203-32-8369 70 10,1942 <u>March</u> Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1X Yes 2 No MD Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3800 Enfield Chase Court #120 20716 ral", or items ? I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural" 3 Widowed 4 X Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur aumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Management Analyst</u> Government Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Charles Henry Wilburn Sr. Katherine Elizabeth Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 Enfield Chase Court #120 Bowie, MD 20716 Stacey L. Chase/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State , Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 11-27-2012 Clinton 21. Signature of Funeral Service License 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road, Hyattsville, MD 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ non-Small Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, it was cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) -transit and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy perform death? performed? Hospital or Attending Physician: The 24 hours after death. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1 🗌 Yes 2 X No 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \(\text{Yes} \quad 2 \(\text{No} \) 1 X Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifiei 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

d

Matilda_H._So

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D26250

Mercantile Lane, Largo, MD 20774

November 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Brown Physician/ Day Q Month 2012 390 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore arblin If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) Min. (Month, Day, Year) Director 1 □ M 2 X F Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28a-f show eny injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No monium 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 USA Valley K210 21093 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. ۵ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry /Secondary (0-12) of Baltimore Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ည Talia Jane 19a_Informant's Name/Relationship 19b. M2390 dd 166 faet eig Nybarreyd Rate Nur 216d or Trimbini Zincode MD 21093 Perrena-Daughka CAUL appa 1 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Baltimore, 4 Donation 5 Other (Specify) 30/2012 21. Signature of Funeral Service Licensee North 110123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Pier Medical resulting in death) Here Thou Due to (s a consequen see a): Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of is after death.
I Director: After this certificate has been signed by the attending physician and in by the funeral director; page 2 should be detached for use as the burial-transit. or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED Live 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? Investigation 3
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30 60 2012 of death (Item 23a) (Type, Print) 5/RFE Blua limole Kaven 31. Date filed (Month, Day, Year) State Registrar NOV 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1tems 20a-c per fh 1-28-13 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis tome Birthplace (State or Foreign Country) If Und 8. Date of Birth (Month, Day, Year) 8-23-195 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 60 Yrs. Months Days Hours Min. 216-58-1555 1 № M 2 🗆 F 23-1952 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be rediffed a once. 1 ☑Yes 2 ☐ No Director timore MU 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Sain USA 21212 unstans Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 **1**0 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐Yes 2 █ No Specify: ٥ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT, use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) rrectiona 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Sarah ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Typ-. Print) Gloria Sister 6303 Parietta 20c. Location - City or Town, State 20b. Place of Disposition Date 20a. Method of Disposition Ba1timore 1 ■ Burial 2 ■ Oremation 3 □ Removal from State 22. Name and Address of Facility Vaughn C. Greene Fundral Services
4905 Val D. D. D. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic Koad 4905 13a MO 21212 York 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one complete on each line. Immediate Cause (Final disease or condition resulting in death) Physician 15ease DYDnay /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit and ue to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown icate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed? 1 ☐ Yes 2 ☐ No 2 1 N 1 ☐Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month Day, Year) 29b. Signature au 29c. License number Name and address of person who completed eduse of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 821 Registrar's Signature State NOV 2 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 4 M Joyce November 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10-27-19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 F 63 216-54-617 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director Limore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 4009 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 ☐ Divorced 13/ac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental In int: if item 27 Is marked of 19a. Informant's Name/Relationship (Type. Print) Selina Du 20b. Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition Department of 1 Burial 2 Cremation 3 Removal from State 5 of Faith 12-3-2012 Baltimore MD 22. Name and Address of Facility Vaughn C. Greene Funeral Services 4905 York Road Baltimore, MD 21212 4 Donation 5 Other (Specify) 21. Signature of Fureral Service Licensee con ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter The disease, shock, or heart failure. List only Immediate Cause (Final disease or condition ASCVO long stand ny Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or it jury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 🗌 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Tyes this certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 🗆 Nursing Home 2 M ER/Outpatient 3 □ DOA 5 Residence 6 Other (Specify) ၉ filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 24 hours after death. Funeral Director: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2

Box 68760.

State Registrar

Hardin 31. Date filed (Month, Day, Year) NOV 2 9

29b. Signature and title of certifier

funth. mg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

back

29c. License number

D-0061115

29d. Date signed (Month, Day, Year)

November 26, 2012

4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 9 per fh. g936 2/1/13 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:59 PM BROWN NOV 20 2012 ISABELLA LORRAINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WALTER REEL NATTONAL MILITARY MEDICAL
5. Social Security Number 6. Sex BETHESDA MONTGOMERY CENTER 9. Birthplace (State or Foreign Country) **Bahrain** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days (Month, Day, Year) Director None 1 □ M 2 🗓 F 17 08/04/2012 Maryland ir then "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at end 2 should be filed within 72 hours efter death with the Maryland Heelth end Mentel Hygiene. tem 27 is marked other then "nature!", or Items 23e or 28e-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Milton 1 Yes 2 No Florida Santa Rosa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 9787 South Trace Road 32583 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done (life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Daniel Brown Susan C. Menezes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth e 9787 South Trace Road, Milton, Florida 32583 Susan C. Brown - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pege 1 of Bepartment of Importent: If its eny injury or of once. ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Lincoln Crematory 12/03/2012 Brentwood. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockyille Pike, Rockyille, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician/ PONTOCEREBELLAR HYPOPLASIA Medical resulting in death) Due to (or as a consequence of): Examiner TONIC SPASTICITY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or se a consequence or, ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury HYPOVENTILATION that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖫 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe After this certificate 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔯 No Certificate: To 1 XInpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours at Euneral D Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funel

completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL CENTER

Registrar

DHMH 17 Rev 06-2011

State

BRIDGET K.

NOV 2 9

31. Date filed (Month, Day, Year)

CUNNINGHAM,

2. Registrar's Signature

BETHESDA.

MD 20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Catonsville 7304 Inwood Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral MD 76 **Director** 217-34-5984 1 □ M 2 🗗 F Sep 8, 1936 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director or 28a-f 1 Yes 2 No **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a U.S.A 21228 7304 Inwood Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: Black If Yes. Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Indoor Maintenance Housekeeper 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Young Alexander Barbour Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7304 Inwood Avenue Catonsville, MD 21228 Brenda Stanley Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Injury or Nov 23, 2012 Baltimore, MD Loudon Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 reiof Funeral 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final periphenal vascular Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate nause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending o 24 hours after death.

Funeral Director: After the function of the function 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

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Medical

State Registrar

29a. Certifier

29b. Signature and title of certifier

Smith 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DOOS 7465

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 1 Month 20^{Year}2 9:50 PM Physician/ JOHN HOWARD BUNN Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Orchard Beach 7903 Waterview Drive Birthplace (State or Foreign Country) 8. Date of Birth Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Social Security Number **Funeral** Days 0 7 18 1945 1 **X** M 2 □ F MD 67 218 44 2961 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County must be notified at Director 1 Yes 2 No Orchard Beach Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 23a Funeral U.S.A. 21226 7903 Waterview Drive ural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married Completed by hours after 1 ☐ Yes 2 X No Specify: 3altimore, Maryland 21215-0036 If Yes, Give White 3 Widowed 4 Divorced Year or Dates er than "natura", the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) United States College (1-4 or 5+) Elementary/Seconday (0-12) Coast Guard Yard Electrician 12 h and Mental Hygier 7 is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa Hubich ည Gerald R. Bunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health an Important. If item 27 is any injury or other trau. Once. Orchard Beach, MD 21226 7903 Waterview Dr Barbara Bunn - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/27/12 Baltimore, MD Cedar Hill Cem 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service icensee 22. Name and Address of Facility GJ Gonce Funeral Home, Drive Pasadena, MD 169 Riviera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition 5 year PROSTATE CANCER Physician/ METASTATIC resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes Certificate: To 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 27. Manner of Death Natural 5 Pending 1 Yes 2 No Investigation Accident 24 hours after deat Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R157914 pulsant coms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24A MAGOTHY BEACHED Pasadena MD 21122 GASTCRNA MARY K. 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PM Margaret Culver 3 701 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Year If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □X Days Hours Min. Country) 216-42-4249 0 1 2 6 / Par 9 4 4 MD Director 68 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland must be notified at Director N/A 28a-f MD Baltimore 1 🔀 Yes 2 □ No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 items 23a U.S.A. 4201 Parkton St. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 X No Yes, Give 1X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 7th College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I marked o ပ Roy Culver Georgianna Parker and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Brisbane Rd. Baltimore, MD 21229 Patsy Thomas (Sister) item Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD On-Site Crematory 21. Signature of Funeral Service Joseph H. Brown Jr. Funeral 21217 2140 N. Fulton Ave. Balto., MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Smal 0 Months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner vear Sequentially list conditions, Examine if any, leading to ininectate cause. Enter Underlying Cause (Disease or linjury that initiated events pue to joi as a consequence of) Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be ex 24 hours after death. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 XYes 2 No 3 Probably 4 Unknown ivision of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy ☐ Yes 2 🔼 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No 1 🗌 Yes ျှ 1 X Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11011 26 Nov 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) Perring Parkway Parkville Genesis Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1**X1X**4 2□ F Months Days Hours Min. 94 217-54-3236 Spain Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show r than "natural", or items 23a or 28a-f show the Medical Examination will be multified at 1 ☐ Yes XXNo Director Parkville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8804 Wilson Avenue 21234 United States Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1X Yes 2 □ No Specify: Specify: White ģ ¾ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. Bethlehem Elementary/Secondary (0-12) College (1-4or 5+) Master Carpenter Steel 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Crujeiras Maria Millares ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2801 Haddaway Court, Abingdon, MD 21009 Gonzalo Crujeiras Son Date 30, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Parkwood Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Evans Funeral Chapel &
8800 Harford Road, Park

23a. Part 1. Entering disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22 Name and Address of Facility Evans Funeral Chapel & Cremation 8800 Harford Road, Parkville, MD Syrs. 21234 Approximate Interval Between Onset and Death Immediate Cause (Final Physician mei disease or condition resulting in death) /Medical ue tra (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit resulting in death) Last or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year ates 951 PM NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOPKINS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 212-40-4871 Director 1 1 M 2 14 MD 2-12-1944 of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 13/ac 3 ☐ Widowed 4 ☑ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use 1stired) condary (0-12) College (1-4 or 5+) aci Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumam ge 1 and 2 should be nt of Health and Mer :: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print)/ 19b. Mailing Address (Street and Number or Rural Route Number_City or Town, State, Zip Code) Son Baltimore MD 21218 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other 20c. Location - City or Town, State permit. Page 1 a Department of H 1 Burial 2 Cremation 3 Removal from State injury or mportant 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee M0166 21212 Part 1. Enter the disease, or commencations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury PILEPS for use as the burial-transi The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the at I be detached for <u>P</u>0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examiner? 2 🗆 No 1 Inpatient 2 PER/Outpatient 3 IDOA ᅆ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending ☑ Natural 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat D65854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 BALTIMORE TOLBAM EANS 31. Date filed (Mont 32. Registrar's Sig State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ 11:59pm Elizabeth Rajan Charles 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Adelphi 1912 Hampshire Drive 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours **Director** 578-86-7355 1 □ M 2 🗓 F 67 02/04/1945 India Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27.7 is marked outher than "natural", or items 23a or 28a-f sho ury or other traumetic event, the Medical Examiner must be notified at ury or other traumetic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ☐ Yes 2 X No Adelphi Prince George's Maruland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20783 1912 Hampshire Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Asian Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) World Bank Administrative Assistant 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thankamma Samuel P.S. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1912 Hampshire Drive, Adelphi, Maryland 20783 Rajan Charles - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of h Important: If ite eny injury or ot 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem: 12/02/2012 | Adelphi, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature of Funeral Service to insee MOUZUA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stage IV Metastatic Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> cate has been signer r, page 2 should be d 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 26, 2012

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Katherine David,

31. Date filed (Month, Day, Year)
NOV 2 9 2012

H0055125

5530 Wiscinsin Avenue, #1149, Chevy Chase, Maryland 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:25 PM 6, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EBREW MONTGOMERY OCKVILLE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) Funeral MOTO 27/1969 158-52-7009 North Dakota Director 43 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 X Yes 2 □ No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 6121 Montrose Road 20852 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 Widowed 4 X Divorced White. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Food Service Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Richard Cooper Marsha Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 Thornbush Court, Bethesda, Maryland 20814 Linda Cooper Slan - Aunt Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lincoln Crematory 12/04/2012 Brentwood. Maryland 22 Name and Address of Facility
Simple Tribute Funeral & Cremation Center
1040 Rockville Pike, Rockville, Maryland 20852 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONITIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 5PHAGIA Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit USCULAR DYSTROPHY the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending X Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier NOVEMBER 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOCKVILLE, MD 20857

Registrar DHMH 17 Rev 7/2009

State

MONTROSE

M.D.

6121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ M Louise Carter 2012 9.55 Medical November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4821 Vicky Road Nottingham Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 216-34-9400 Director 1 M 2 X F 73 7/31/39 Maryland Usual Residence of Decede 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits the Maryland at Director notified 28a-f 1 🗌 Yes 2 🔀 No Nottingham MD Baltimore ms 23a or 2 must be no 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 4821 Vicky Road 21236 USA items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iten I Examiner r 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify "natural" Completed 3 ₩Widowed 4 Divorced White er than "natura , the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Race Track 12 salth and Mental Hygien n 27 is marked other ther traumatic event, the Teller / Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Linwood John Tall Julia Elizabeth Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherry L. Donnelly / Daughter 4821 Vicky Road Nottingham, Maryland 21236 t: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Department o Important: If any injury or once, 11/29/12 Loudon Park Cemetery Baltimore, Maryand 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home Baltimore, Maryland 21229 ugz 3620 Wilkens Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer hero Scleratic CANDIO VASCA LAN disense Immediate Cause (Final Onset and Death Physician/ ass disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year be detached the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed 2 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 - No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: Af Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifi 29c. License number (Car) N. Charles St. Balts. and 2120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year) _ 32. State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AM Joyce Ann Duncan 12:17 Medical November 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1225 Splashing Brook Dr. <u>Abingdon</u> Harford Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Country) Baltimore Min 218-96-9747 Director 1 🗆 M 2 🔀 F 48 June 12, 1964 Maryland 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1225 Solashing Brook Dr. 21009 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. ☐ Yes 2 No ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Asst. Manager - Geresbecks Food Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Donald Ray Duncan Virginia Louise Speed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Mrs. Robin Glode (Cousin) 1225 Solashing Brook Dr. Abinodon, Maryland 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State . Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel 2, 2012 Dec. Forest Hill, Maryland 21. Signatura f Funeral Service Licensee Jeffrey R. Testerman 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air Restection (MO1543) 3 Newport Drive, Forest Hill, Maryland 21050 23a. Phys. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ovana oana k disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for i Pregnant at time of death 5 Other (specify) Month Day Year After this certificate has been signed by the functional director, page 2 should be detached g 🗌 Unknown g 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of perform

Yes 2 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No ျာ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۵ 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State filled in within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 8 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of M	ai yiai k	•	tificate			and w		Rea. No.		0	0.00	
			Decedent's Name (First, Middle,	Last)						T	2. Date of Dea	ath	201	2	3. Time of	Death
	Physicia Medic		Lillian Fay	Duleba					_		Month Novembe	er 25	y 201	2	2:35	P^{M}
	Examin		4a. Facility Name (if not institution,	give street and number)					Location o	f Death			. County of D	eath		
-			Hart Heritage I				Str						Harford			
	Funeral			6. Sex 7. Ag		st birthday)	If Under Months	1 Year Days	If Under :	Min.	8. Date of Bir (Month, Da	y, Year)		Birthpla Country	ce (State or)	Foreign
	Director		215–24–3949 Usual Residence of Decedent	8	4 Yrs.					Dec. 1	2, 1	927 N	Mary.			
	and show	ō	10a. State 10b. County		10c. City	Town or Loc	cation							100	I. Inside Cit	y Limits
	Maryli Ba-f	Director	Maryland Harfo	ord	Bel	Air									1 🗌 Yes	2 🗆 No
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at		10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of What	Country	/?	
	ıs 23. nust	Funeral	5 Vermont Pl.					1014					5.A.			
	death Item ner n		11. Marital Status	12. Was Decedent Armed Forces?		. 13. V	Vas Deced f Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		14. Race - A Black, W			
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Marr 3 🔀 Widowed 4 ☐ Divorced	If Yes, Give	No	1	☐ Yes	2 🔀 No	Specify:				Specify:	Whit	:e	
ဝို	atura ical E	Completed		Year or Dates. t's Education		16a. Deced						16b. K	and of Busine	ess/Indu	strv	
215	n 72 l	틹	(Specify only highe: Elementary/Secondary (0-12)	st grade completed) College (1-4 or	5+)		kind of wor O NOT use		uring most	of worki	ng				,	1
21	withi giene rer th		12			Homen	naker						n Home			
Б	filed tal Hy d oth	To Be	17. Father's Name (First, Middle, L	ast)							(First, Middle,	Maiden :	Surname)	Unkc	wn	
₹	Id be Ment narke		Vernon Armour						Mary							
Mai	12 shou lith and 27 is m r treum		19a. Informant's Name/Relationsh				•	•			Route Numbe				de)	
- -	and Healt		Mr. David Duleba 20a. Method of Disposition	a (SOII)	20b. P	ace of Dispo			Ave.		i Sprir		ocation - City		n. State	
nor	permit. Page 1 a Department of h Important: If its any injury or of		1 1 Burial 2 Cremation 4 Donation 5 Other (S	3 Removal from State	, α	emetery, cren	natory or o	ther plac						_		
Baltimore, Maryland 21215-0036	nit. P. artme ortan Injur	Н	21. Signature of Funeral Service L								0, 2012					
B	permi Depar Impor any Ir		Solly R &		1543)	LIGHT EX	vans Fl	nera + Dr	L Chape	él&(mest	remation	ı Serv	ziœs – rd 2105(Bel.	Air	//
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.												1	oproximate	
1	Physician/		Immediate Cause (Final disease or condition a END STAGE DEMENTA										3	Onset and D	Death ,	
	Medical Examiner		resulting in death)	a. Due to (or as										1,	100	,
	Examiner	۱,	Sequentially list conditions, b. Due to for as a consequence of:											+		
	sit sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):														
\X	icate be executed physicien and is the burial-transit	xa	that initiated events resulting in death) Last	ence of):								+				
o o	ficate be execting physicien and as the burial-tra	edical														
)9/	icate p phys	-		- a.												
89	certif		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			T Ectopic r	vegnanc	v			- 4	23d. Date o	f delivery	/	
Box 68760	death certif ne attending led for use a	Physician/N	in the past 12 months? 1 Yes 2 No	4 Pregnant			Other (sp		,				Month	D	ay Y	ear .
P.O.	t the by the	Phy	9 ☐ Unknown Part II. Other significant condition		but not mo	ulting in the u	un dorbein a	auco div	on in Part	1	OD Did		use contribut			anth?
σ,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use a	ρ	Part II. Other significant conduct	ins contributing to death	Dut not les	uiting in the c	inderlying (ause giv	GITIII F COL	1.		Yes 2	. /		bly 4 □ l	
rds	equin	etec			-								′			
တ္ထ	has b	Completed			-						24a. Was auto perfe	psy	prior	r to com	y findings a pletion of ca	ause of
Ä	n: The ficate or, pag		25. Was case referred to medical					OC DI	ace of Dea	th (Chaol	1 Yes	2 N	o 1 🗆	Yes 2	155is	Le D
/ita	sicial s certi directo	To Be	examiner?	Hospital:	tiont 2 🗆	ER/Outpatier	o+ 3 □ D	Othe	Vr.		me 5 🗆 Resi	idanaa 6	E Debar (S	Enociful	CA	
Division of Vital Records,	Attending Physician: or death. ector: After this certific by the funeral director.		27. Manner of Death	28a. Date of inj	ury	28b. Time of injury		8c. Injury	/ at	-	28d. Describe			респу)		
u	ath. r: Aft	icat	1 Natural 5 Pendir 2 Accident Investi	gation	iy, 16ai)	ніјску	м	work	Yes 2	l No						
/isi	r Atte ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Hornicide determ		jury - At ho tc. (Specify	me, farm, str	eet, factory	, office			28f. Location (r Rural R	oute Numb	er,
Ö	oital o urs af rral Di									11						
	Hosp 24 ho Fune etely	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of Nurse Practitioner: To the	examination	and/or inves	tigation, in	my opinio	n, death o	ccurred at	the time, date	and place	e, and due to	the caus	e(s) and ma	nner stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Σ	only one) 3 LI Certifying 29b. Signature and title of certifier	Nurse Practitioner: To t	no cost Of II	, mowneage	290	. License	number	and pla	os, and due to	29d. Da	ite signed (M	Ionth, Da	y, Year)	
			· IANA	M M	0		~	3	98	80	7	NOU	'LMRe	27	, 20	12
	5		30. Name and address of person	who completed cause of	death (Item	23a) (Type, F	Print)		110	^	0 1 1	. 1	41 N	_		
)		/ 10	SPARICS	6	150	V. MAC	PH	11/2	2,1	Sel A	in	(ורע	410	17	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 9 2012	32. Regist	rar's Signal	a Ken					Î					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Barbara Earle Dunlap 2012 12:28 p November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) Director 88 1 ☐ M 23**CM**F 197-28-7437 Yrs Pennsylvania Nov 5, 1924 th and Mental Hygiene. 27 is marked other than "neturel", or Items 23e or 28a-f shov traumatic event, the Medical Example invasible notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Cockeysville 1 🗌 Yes 2 🛮 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13801 York Road 21030 U.S.A. Apt. R8 permit. Page 1 end 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items eny injury or other traumatic event, the Medical Exemter or 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanor Earle Harold Lehman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 East Melrose Avenue Baltimore, MD 21212 Paige Knipp daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Commation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/30/2012 Baltimore, MD Crematory 22. Name and Address of Fapilitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mydoma multi disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of rigury that initiated events Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the deeth certificate be executed physicien end s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No eral Director; A 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined nin 24 hours a the Funeral C mpletely filled Medical 29a. Certifier TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the I Complete only one Signatu License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). UtARLES 21204 (M 6701 N. 31. Date filed (Month, Day, Year) NOV 2 9 2012 32. Registrar's Sig Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November of 4:50 PM Anna E. Dunn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Mustimedical Certer Beltemere Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth (Month, Day, Y **Funeral** Hours Months Director 213-20-4336 9 1914 Jan. Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 28a-f MD Baltimore Towson 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral USA 21204 7700 York Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify. 3 ▼ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 8 n/a Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Eleanor C. Norton William J. Stricker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Kenilworth Park Dr. Apt. 1B, Towson, MD 21204 Mary Lou Mathis/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/28/12 Parkville, MD Parkwood Cemetery 21. Signature of F and Se Licensee

Michael K Flagle 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia Advanced disease or condition resulting in death) 1825 Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause E. Let Underlying Cause (Disease or iinjury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by templeted filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 🗌 Yes 2 🗌 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 12 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

NOV 29

DHMH 17 Rev 7/2009

300

Kalender Genesis Multimedical Center 7700 York Road Towson, Maryland 21204

cause of death (Item 23a) (Type, Print)

November 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ NOVEMBER 26 2012 02:12P M DAFNER MICHAEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A GOOD SAMARITAN MEDICAL CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 212-11-6294 Director 1 🕅 M 2 🗆 F 10/06/1985 MD 27 Usual Residence of Decede 10d. Inside City Limits than "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🂢 No BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral USA 21117 3745 ASHLEY WAY 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give 3 Widowed 4 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. ondary (0-12) College (1-4 or 5+) NONE NONE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F 27 is marked o traumatic eve ၉ Pe DAFNER BETH GOLDBERG DAVID t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3745 ASHLEY WAY, OWINGS MILLS, MD 21117 DAVID DAFNER/FATHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I Important: If its any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 11/28/2012 RANDALLSTOWN, MD 21. Sig 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service L 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications shock, or heart failure. List only one s that c Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Xeav'S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami that the death certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 4 Pregnant at time of death ned by the at a detached fo 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? this certificate has been signed and irector, page 2 should be de Completed by the Hospital or Attending Physician: The law requires 2 🗹 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one and title of certifie 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20perpHYS, G933, 11729/20 12, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9 Day Physician/ Nov. 20\f2 ELLIS 9:53 a WORSTER LEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Brentwood 4544 41st Ave. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Months Days Hours (Month, Day, Year) Director 1 🔀 M 2 🗆 F 251-50-4881 Feb. 18, 1932 SC 80 Usual Residence of Deced "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 2004 Trenton Pl SE 20020 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🖾 No Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Johnson Tree Service 6th Laborer permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. H. Ellis Agnes Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coretta Ellis - Daughter 2004 Trenton Pl SE Washington, DC 20020 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harmony Memorial Park 11-14-2012 Landover, Md 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland colarine 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ maliananT disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a constituence of attending physician and for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown s after death,

I Director: After this certificate has been signed by the a'
id in by the funeral director, page 2 should be detached f Yes 2 No g 🔲 U*n*known Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Home Hospital: Other: 2 🔀 No 1 🗌 Yes |ဇ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No М Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. "Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 K Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) 8 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Ellingsen Sachara 0540 AM Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death . PENINSYUN BEGIONAL MADICAL SALISBULA NICOMICE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217 34941 **Director** 1 M 2 M 73 4/18/39 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is merked other then "natural", or items 23e or 28e-1 show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 28e-f show 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Quantico 1 Yes 2 No licomico 10e. Street and Number 10g. Citizen of What Country? Funeral 25395 21856 ane USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Domestic College (1-4 or 5+) 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ reorge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salislary, MD 31804 Ellingsen Ave AptIC sinno /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory 11-25-12 JESSUPIPAISH34 4. □ Donation 5 □ Other (Specify) AM 370 Fredhiltenfos 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home PA BaltoIMDallag Genod Gary P. March Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ravs Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Exami resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Dres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 🗌 Yes 2 🗆 No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature le of certifier 29d. Date signed (Month, Day, Year) 36783 30 Name an leted cause of death (Item 23a) (Type, Print) SAUSSURY, MD 21801

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brian Howard Eane	1	- For State	Sta	ate c	of Maryla		epartme Certifica:		Health ar Death	nd M	/lental Hy	/giene	Reg. No	2 (- Appendix	2 3825
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Funeral Director	5	Social Security N		6. Sex	M 2 F	7. Age (In y	yrs. last birtho	lay) Yrs.	If Under 1 Year Months Day		Under 24Hrs. Hours Min.	7	Birth(MM 06/1		Foreign	nplace (State or noting) MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Mai	2 sho th and 27 is r traun		Alvin Frager, Son	Alvin Frager, Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Alvin Frager, Son 106 Autumn Hill Way, Gaithersburg, MD 2									
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	De		30. Name and address of person who con Patricia Gomez, M.	•			Suite 1	30. Roc	kville	e. MD	20850		
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QHMH 17 Rev 7/2009 *

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First_Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 1173 E. Northern Pkwy. Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 217-38-1889 Months Days Director 1 □ м 2**X**□ F 03/19/1930 MD ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland irnent of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoilury or other traumatic event, I're Medical Examinar must be notified at 10a State 10b. County Director N/AMD 1 Tyres 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21239 U.S.A. 1173 E. Northern Pkwy. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. δ 1 Never Mamied 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ely Laundry Laborer 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Sophie Brown John Wesley Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Waters (Daughter) 1173 E. Northern Pkwy. Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State $11/\overline{30}/12$ |Crownsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Funeral Home PA Balto., MD 21217 22. Janesad Address Pf. Fac Brown Jr. 2140 N. Fulton Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) uterine cancer Physiciani Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

WS Ref CARCON MID 29d. Date signed (Month, Day, Year) D0057465 11/27/12 Baltimore MDZ1209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSAUGUSEM 2835 Sm/M NS2) 2835 Smm NS:203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 2012 Registrar

Projection Rockonstrate Name (First Most Lati)	12-08932 Richard Gallaghe			or Print in Bl of Maryland	/ Depar	rtment of	Health					gible		10	2225
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vickey Lynn Gerstel **November** 27, 2012 9:40 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Examiner Towson Gilchrist Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 21, 1959 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Director Baltimore,MD. 214-88-4238 1 □ M 2 🖺 F 53 Yrs. filed within 72 hous owners the Hygiene.
ed other than "neturel", or items 23s or 28s-f show
ed other than "neturel" or items 23s or 28s-f show
es event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Timonium 1 Yes 2 No Baltimore County 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 United States 1 Washington Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) 02 Elementary/Secondary (0-12) Clinical Associates Medical Clerk Be permit. Pege 1 end 2 should be filed Depertment of Heelth end Mentel Hy Important: If Item 27 is merked oth any linjuy or other traumatic even 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Anna Mae Kearney Carl Benton Denmyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 Washington Street Timonium, Maryland 21093 1 Washington Street Mrs. Anna Mae Denmyer / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Baltimore County Friday, Nov.30,2012 Dularey Varriey Methorial 1XXBurial 2 Cremation 3 Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ocenses Teffrey L. Cair, Sr. CFS 22 Name and indignitives Funeral and Cremation Center, P.A. Lic.#M00677 21093-2215 2325 York Road Timonium, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician/ Medical Examiner

traumatic event,

Baltimore, Maryland 21215-0036

signed by the ettending physicien end d be deteched for use es the buriel-trensit Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The lew requires that the deeth carlificate be executed within 24 hours effer deeth.

To the Funeral Director: After this carlificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burlel-transit

State Registrar

	shock, or heart-failure. List only one				1	Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. Breast Canc Due to (or as a consequence of):	er			Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
Medic	IF FEMALE:	d				
ıysician/	23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 No 9 Unknown		topic pregnancy ner (specify)		23d. Date of del Month	ivery Day Year
ed by Pi	Part II. Other significant conditions con	ntributing to death but not resulting in the under	fying cause given in Part I.	23e. Did tobacco	1	the cause of death?
Complet				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Be	25. Was case referred to medical		26. Place of Death (Check	only one)		
မ	ILI fes 2 LANNO	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 🗆 Nursing Ho	me 5 🗆 Residence	6 Other (Spec	in hospice
ficate:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		28c. Injury at work? VI 1 ☐ Yes 2 ☐ No	28d. Describe how inji	ury occurred	
I Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, t building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Sta		ral Route Number,
Medical Certificate:	(Check 2 Medical Examin	ician: To the best of my knowledge, death occu ner: On the basis of examination and/or investigati e Practitioner: To the best of my knowledge, dea	on, in my opinion, death occurred at	the time, date and place	ce, and due to the	cause(s) and manner stated.
Ι_	29b. Signature and title of certifier /		29c. License number	29d F	ate signed (Month	n. Dav. Year)

23a) (Type, Print)

completed cause of death (Item)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 3. Time of Death Day 16 Physician/ Year 2012 Brynn Patience Gilley 3:58 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** S784Se558-3272 7. Age (In yrs. last birthday) 8. Date of Birth Months Min (Month, Day, Yea 11/5/2012 NONE Director 1 M 2 F 11 Yrs Usual Resider i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Village Montgomery MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20886 8222 Rainbow View Place U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔽 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Never Worked Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Christopher Paul Gilley Melissa Joy Keyser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher P. Gilley - Father 8222 Rainbow View Place Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Filmportant: If ite any injury or ottone. Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State National Memorial Park 11/24/2012 Falls Church, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility National Funeral Home 21. Signature of Funeral Service Licensee Ma 7482 Lee Highway Falls Church, VA 22042 23a. Part 1. Enter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Necrotizing Entercolitis Medical Due to (or as a consequence of): Examiner Extreme Prematurity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the attending physician and ched for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day sate has been signed by the a page 2 should be detached in 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica ours after death.

erral Director: After this certifics filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TNo 1 3 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 K Natural 2 Accident 5 Pending injury 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 🗌 29b. Signature/and/title,of/certifier 29c. License number 29d. Date signed (Month, Day, Year) rall a DØØ66 134 16 2012 1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chrysanthe G. Gaitatzes 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) NOV 2 9

State

Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

Division

legistrar's Signatur

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #20c Per FH G933 TI/29/2012 JH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOVEMBER 26 2012 GUTMAN 06:34P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 216-01-2569 1 X M 2 D F 101 09/15/1911 MD 28e-f show Page 1 end 2 should be filed within 72 hours efter death with the Meryland ment of Health end Mental Hyglene. Sent: If item 27 is marked other then "nature!", or items 23e or 28e-f show ury or other treumatic event, the Medical Examiner is ust by nutified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No BALTIMORE MD LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 414 BRIGHTWOOD CLUB ROAD 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. چ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) INSURANCE AGENT INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ADOLPH GUTMAN BEULAH ROSENBLATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIDNEY WEIMAN/ATTORNEY 502 WASHINGTON AVENUE, #800, TOWSON, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State permit. Page Depertment of Importent: If eny injury or once. Baltimore 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM CONG. 11/28/2012 REISTERSTOWN, MD 21. Sign fure o Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ icche mic 2 Medical Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sate has been signed by the attending physicien and page 2 should be deteched for use es the burlel-trensit Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 Yes 2 No or Attending Physicien: funeral director, 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Dother (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA huspile 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending To the Hospitel or Attendin within 24 hours efter deeth.

To the Funerel Director: Aft completely filled in by the fun 2 Accident Investigation м 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8363 November 27 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND AMON CHANGES S 6701 N. Choney

State

Registrar

31. Date filed (Month, Day, Year) NOV 2 9 2012

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Francis Nathaniel Green. Jr. 1742 M 2012 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Director 579-94-1838 1 🛛 M 2 🗆 F 11/19/1971 Washington, DC 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Montgomery Germantown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20022 Apperson Place 20876 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Yes 2 No Black, White, etc. Frican-American ecity: à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Server Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental File of Health and Mental Filem 27 is marked or Francis Nathaniel Green, Sr. Sophornia Coston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20022 Apperson Place, Germantown, Maryland 20876 Lakisha Hayes - Spouse other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 e
Department of H
Important: If ite
any Injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 12/04/2012 Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ardiac Arrest Medical resulting in death) Due to (or as a consequence of): Examiner Ucclusion ovonarv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 XNo Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 No 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 KER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Exprimer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying furse Practitioner: To the best of my knowledge, death accurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29d. Date signed (Month, Day, Year) mo 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Chavh

31. Date filed (Month, Day, Year)

NOV 2 9

MD

9901

Medical Center Drive Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 Physician/ 01:52PM BENJAMIN NOVEMBER 2012 GLASS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Director 182-18-7959 1 X M 2 □ F 90 08/12/1922 PA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or itams 23s or 28s-f show eventy injury or other treumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1638 ALSTON ROAD 21204 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER AUTO SUPPLY 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ MORRIS GLASS **STELLA** FARBERLOVICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK GLASS / SON 1638 ALSTON ROAD, TOWSON, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 11/28/2012 CROWNSVILLE, MD 21. Signature of Funeral Service Lines 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Heart failure Tive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause iD. Examine Due to (or as a consequence of): signed by the attending physician and d ba datachad for usa as tha burial-transit pital or Attending Physician: The law requires that the death certificate be executed ours after death.

erai Director: After this cartificate has been signed by the attending physician and filled in by the funeral director, page 2 should be datached for use as the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours e Funeral To the Hospl within 24 hou To the Funer completely fli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Call 20061199 MAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rles St. Suite 4105, Towson MD 212 ack COL 31. Date filed (Month, Day, Year) 32. Registrar's Sig State

ORIGINAL

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TUBEX :50 A DNA VOV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Augsburg Lutheran Home Gwynn Oak 8. Date of Birth

(Month, Day,

June 9. Birthplace (State or Foreign Country)
Maryland . Age (In yrs. last birthday 1 Year If Under 24 Hrs. **Funeral** Months Hours Min 1 🗆 M 2 🗓 F 1922 90 June 212-16-3002 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Gwynn Oak Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 United States 6825 Campfield Road, Apt. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Ves Give White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Home Maker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Schoh1 George Harthausen Minnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Shady Nook Avenue, Catonsville, Maryland 21228 Barbara McElderry / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/29/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Inc Signature of Euneral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter Immediate Cause (Final ANCER Physician disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) nding physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical attending properties for use as been signed by the should be detached has e 2 ျှ

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in 24 hours after death.
the Funeral Director: After th

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F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
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		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to m - cal	26. Place of Death Chec	ck only one)
examiner? 1 Yes 2 No	Hospital: 1	ome 5 Residence 6 Other (Specify)
27. Manno of Death Natural 5 Pending 2 Accident Investigatio		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not to determined	1 38e Clace of Injury - At home farm street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1525

WINGS

State Registrar

DHMH 17 Rev 7/2009

within 2

Certificate:

Medical

29a, Certifier

(Check

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

24000

ame and address of person who completed cause of death (Item 23a) (Type, Print

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2-08924		Please Type or Print in Black Indelible I			ble.	
уга Lee Hairst	on	State of Maryland / Department of Certificate of		_		2 3825
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ledical Exam		I I Y I A LEE HAITS CON		Month D November 2	Pay Year 23, 2012	2020 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		2808 Smoke Tree Lane 5. Social Security Number	Capitol Heights	I Date of Disth	Prince George	
Funeral Director		570 0/ 0001	If Under 1 Year If Under 24Hrs. Months Days Hours Min.		(MM/DD/YYYY) 9. Birth Foreign	Maryland
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ath wi	Funeral	1 X Never Married 2 Married Armed Forces? If Y	is Decedent of Hispanic Origin? (Spi es, specify Cuban, Mexican, Puerto I		14. Race - Americ White, etc.	an Indian, Black,
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21215-0036 nuld be filed within 72 h Mental Hygiene marked other than "n c event, the Medical E	Be C	William Henry Hairston Sr.	Patricia			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Legarnent of Health and Mental Hygiene. Lagarnent of Health and Mental Hygiene. Important: Witem 21s marked other than "natural", or items 23s or 23s-fab. injury or other traumatic event, the Medical Examiner must be notified at once		Lakeyshia Hairston/Sister 7920	6 Glenarden Pkwy	#224 , G	lenarden, M	ID 20706
ore, es lar of Hez If iter		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State crematory or other	ition (Name of cemetery, ner place)	Date	20c. Location - City or 1	own, State
Baltimore, permit. Pages I at a artment of Hes important: If ite injury or other tr	-		oln Cemetery 11/	30/2012	Brentwood,	Maryland
Bafti permit. martn importi					ns Funeral	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	474 Landover Road			20 / 85 Approximate Interval
/Medical	Ĭ	failure. List only one cause on each line. Immediate Cause (Final disease a.Asthma				Between Onset and Death
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o. He d the d by the d ached		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
F. P.O ires that t signed by	d by	Seizure Disorder		1 Yes	2 No 3 Proba	ably 4 Unknown
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Division of Vital Records, tal or Attending Physician: The law require and or Attending Physician: The law require also for each. **All Director*** After this certificate has been sited in by the funeral director, page 2 should b		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Information (Month, Day, Year)		28d. Describe ho	w injury occurred	
Sio Atten r death ector: by the	Cati	2 Accident Investigation 28e Place of Injury At home farm street	1 Yes 2 No	29f Looption (Cto	not and Number of Dur	- B- t- N - b- Oit
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	it, factory, office building, etc.	or Town, Stat	eet and Number or Rur e)	al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit.		29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occur	red at the time, date and place, and	due to the cause(s) and manner as state	d.
omple omple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	ion, in my opinion, death occurred at	t the time, date an	d place, and due to the	cause(s)
CI ESEO	ž	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mon	th, Day, Year)
.OV			O.C.M.E.		November 24, 20	12
OCME		Name and address of person who completed cause of death (Item 23a) Mary G. Propie MD. Deputy Chief Medical Examiner 900	W Baltimore Street Baltim	OFE MD 242	23	
	tate		vv. Dailinore Street, Baltin	101e, MD 212.	دی	
Regis			atel			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Las	et)		Cer	tificate	e or D	eain		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia		Lawrence V. Ha								Month Novembe	Day	2012	10:41 A ^M
-	Medic Examin		4a. Facility Name (if not institution, give			_	4b. City,	Town, or	Location o	f Death	TIOVENDE	4c. Cou	nty of Death	
			Gilchrist Center				Tow	son				Bal	timore)
	Funeral		5. Social Security Number 6. S		e (In yrs. last t	birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	v. Year)	Coun	olace (State or Foreign try)
	Director		215–16–2115 Usual Residence of Decedent	XXM 2 □ F	89	Yrs.					March 2	4, 1923	Balti	more, Maryland
	and show	ō	10a. State 10b. County		10c. City, To								1	0d. Inside City Limits
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	1 and 2 should ba filad within 72 hours efter death with tha Maryland if Haaith end Mantal Hyglena. Item 27 ia marked other then "natural", or items 23a or 28s-f show item 27 ia marked other then "natural", or items 23a or 28s-f show other traumatic event, the Medical Evariable must be notified at	Funeral Director	2716 Maple Avenu							1.0.00				
	r deat		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?		13. V	Vas Deced Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican	in? (Spe , Puerto	cify Yes or No- Rican, etc.)		Race - Americ Black, White,	
936	ai", o	Q D	3 Widowed 4 Divorced	1 □XYes 2 □ If Yes, Give Year or Dates.	NO	1	☐ Yes	2 🛛 No	Specify:			Spec	city: Wh	nite
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Maryland	should ba file n end Mantal I 7 ia marked o raumatic eve		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	a Address	(Street a	and Numbe	r or Rura	I Route Numbe	r, City or Tow	n, State, Zip (Code)
	d2shalth e alth e 27 is	П	Mary Hagen (Spou	se)							kville,			
ore,	of Haal of Haal fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			e of Dispo	sition (Nan	ne of ther place	e) .		Date		on - City or To	·
Ë	Page 1 mant of tent: If it	П	4 Donation 5 Other (Speci				emeter			Nover 201	ber 30, 2	Parkvi	lle, Ma	ryland
Baltimore,	parmit. Page 1 a Dapartmant of h Importent: If ite sny injury or of		21. Signature of Finneral Service Licen	See X I I /		22	. Name an Evans	d Addres	s of Facility	acel acel	& Cremat irkville,	ion Serv Marviar	zices Pa d 21234	rkville
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only o	plications that cause	d the death. D	o not ente								Approximate Interval Between
	Priysician/	8 8	Immediate Cause (Final disease or condition	L L	211 1+	_								Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as	a consequen	ce of):								
	LXamme	٦ ا	Sequentially list conditions,	b. —									_	
1	ad nsit	퉅	if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury	Due to (or as	a consequen	ce on:								
26	xacut	Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequen	ce of):								
Box 68760	cata ba axacuted physician and s tha burlal-transit	edical Examiner		d										
876	ng phy as th		IF FEMALE:											
9 X	th cer tendii or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 Fetal de	eath 3 🛚	Ectopic p		y			23d	Date of delive	rery Day Year
8	tha at	Completed by Physician/M	1 Yes 2 No 9 Unknown	4 Pregnant a 9 Unknown	at time of dear	th 5L	Other (sp	pecify)					W.C. III.	July 100.
P.O.	hat th ad by datac	y P	Part II. Other significant conditions	contributing to death I	out not resulti	ng in the u	ınderlying	cause giv	en in Part	ļ.	23e. Did t	obacco use o	ontribute to t	he cause of death?
S,	lines t sign lid ba	d b	Covenary arter	1 disease	COP	0	D	em.	4-77	4	10	Yes 2	lo 3 🗆 Pro	bably 4 🗌 Unknown
Ö	w raqu s bear 2 shou	plet									24a. Was			psy findings available empletion of cause of
Žec	Tha le	Ĕ				·					perfo	ormed? 2 □ No	death?	·_
<u></u>	striffice actor, i	B B	25. Was case referred to medical examiner?	II				_	ace of Dea	th (Chec	k only one)			
Ξ	Physic this ca	₽	1 Yes 2 No 27. Manner of Death		ient 2 ER				4 🗆 N	ursing Ho	me 5 Resi			nhospice
0	ding F h. Aftar funer	ate	1) Natural 5 Pending	28a. Date of inju (Month, Da	ny, Year)	Bb. Time of injury	M 2	8c. Injun! work 1 □	yat :? Yes 2□	No	28d. Describe I	how injury oc	curred	
Sio	Attender dat ctor:	ĮĔ	2 Accident Investigation 3 Suicide 6 Could not lead to determined	28e. Place of In		e, farm, str	_		163 2	110			mber or Rura	Il Route Number,
Division of Vital Records,	s after	ပ္	4 LI Hornicide determined	building, et	c. (Specify)						City or Tox	vn, State)		
	To the Hospital or Attending Physician: Tha lew raquires that tha daath cerlificate ba axacuted within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and complately filled in by the funerel director, page 2 should be dateched for use as the burlal-transl	Medical Certificate:	(Check 2 Medical Exam	vsician: To the best on the basis of the bas	examination ar	nd/or inves	tigation, in	my opinio	on, death or	ccurred a	t the time, date a	and place, and	due to the ca	ause(s) and manner stated.
	To the within To the somple	Σ	29b. Signature and title of certifier	se Fractuolier. 10 ti	ie best of my i	Kilowieuge			number	te and pi	ace, and due to		gned (Month,	
			> Alan	Um				Do	5 8	30	3	Nove	wher !	26 2012
	ILY		30. Name and address of person who	completed cause of	10	Ba) (Type, I	Print)	w	5 S		TONSON	, n	\sim	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 9 2012	32. Registr	rar's Signature	1 ,	,				707		· · · · · · · · · · · · · · · · · · ·	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November Physician/ HEATH EDWARD 12:10 F M LEROY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NORTHWEST 400 SPITAL RUNDALLSTO WN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 219-26-5980 1 □XM 2 □ F 2-25-1941 MD 10a. State 10c. City, Town or Location item 27 is marked other then "naturei", or items 23e or 28a-f sho other treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6258 Robin Hill Road 21207 USA 11. Mantal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2A No
If Yes, Give
Year or Dates. Black White etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th **Machinist** Construction Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F မ permit. Page 1 and 2 should be Department of Health and Ment Importent: If item 27 is marke eny injury or other treumetto t Thomas Heath Julia L. Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald S. Heath Sr., / Brother 5302 Lewellen Avenue., Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 11-26-2012 Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Rd., Randallstown, MD 21133 23a: Part 4. Enter the disease, or competitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final MUOCARDIAL Physician/ NEXPLOTION disease or condition resulting in death) Medical Due to (or as/a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 98 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 1 Yes 2 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>á</u> CANCER Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physicien: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s autopsy 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 17 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Division Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 054352 NOVEMBER 24 2102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Min CDA TO DOIC NORTHWEST HOSPITAL, Shot OLD COURT ROAD RAW SALLS TOWN 21133

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ dith Louise Hoes Month 7:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Willowdale Dr #24 Frederick Frederick If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday **Funeral** Hours 218-24-1193 Director 1 M 2 X F 1923 Mary land ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location Director Frederick Frederick 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 145 Willowciale Dr #24 Funeral US 21702 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? o Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black is marked other than "natural", 3 X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) senior Citizens of Elementary/Secondary (0-12) College (1-4 or 5+) Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Notan Marie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Hoes-Daughter 16 West Stone Dr Apt 1 Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) cemetery, crematory or other place, 11-29-12 Frederick MB 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 110 w south st LPollins one Freduck mp 2170 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death
Unknown Yes 2 No 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medica Place of Death (Check only one) examiner? Hospital Other ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Cathame HANES 2.25PM 2012 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Cane Charles Village Balt more MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 3–10–1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🛱 F 214-12-4239 93 GA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3934 Grantley Road 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐ Yes 2 TNo Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: African-American Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dennis Williams Lobenia Herring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Hawes/Son 905 Glenarthur Street, Wilmington, NC 28412 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-30-2012 Arbutus Memorial Park Arbutus, MD 22. Name and Address of Facility Wile Funeral Home P.A. of Halto. Co. 21. Signeture of Funeral Service Chensee 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HUGTZ Due to (or as a consequence of): 126hrc Souler tially list conflictions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Mis Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 ☐ No 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 1 TYes 2 No M investigation 2 Accident 3 ☐ Suicide

Examiner physicien and the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,人 as esn jo signed by the e should b this certificate has ral director, page 2 or Attending Physicien: After death. within 24 hours after death To the Funerel Director: , completely filled in by the f le Hospitel

Physician

/Medical

Examiner

Funeral

Director

other than "naturel", or Iteme 23a or 28a-f show vent, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. ant: If Item 27 Ie marked other than "naturel", or Ite iry or other treumatic event, the Medical Examina

Depertment of Important: If eny injury or once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

Examine

Physician/Medical

Completed by

Be

Medical Certification: To

the Maryland

Alth

IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 27. Mannecof Death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

D31464

BALTIMORE MD 2/201

State Registrar

31. Date filed (Month, Day, Year) NOV 2 9 2012



MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ 2012 1935 M Ann C. Hoskins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 205-16-2047 1 □ M 2 🗓 F Yrs. 84 April 17,1928 Pennsylvania 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medicel Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2 No Hillandale Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20903 2013 Edgewater Parkway 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Secretary 12 alth and Mental Hygie 27 is marked other r traumatic event, # Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lena Venuto Joseph Carilli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3520 Marlbrough Way, College Park, Maryland 20740 Health tem 27 Robert W. Gray - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Gate of Heaven Cem. 11/30/2012 Silver Spring, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signatore of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Septic Shock with Neutropenia Medical Due to (or as a consequence of) Examiner Small Bowel Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami Cause (Disease or injury that initiated events resulting in death) Last Pancreatic Cancer with Metastasis Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2 autopsy performed 1 Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3 DOA After this funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation after deatl Suicide 6 Could not be 24 hours after de Funeral Directo Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Funel completely fi (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) D73240 November 22, 2012

State Registrar

DHMH 17 Rev 06-2011

1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.,

Anisha Kumar,

31. Date filed (Month, Day, Year) NOV 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:15 pm Physician/ November Norma Bishara Hishmeh Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City 8225 Stone Crop Drive, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 220-60-4770 1 □ M 2 X F Director 01/27/1953 Washington, DC 59 Usual Residence of Deceder 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State death with the Meryland rei", or iteme 23e or 28a-f eho Examiner must be notified at Director 1 🗌 Yes 2 💢 No Ellicott City Howard Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number u.s.A. 21043 8225 Stone Crop Drive, Apt. L Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed Year or Dates al Hygiene.
ed other then "ne.
-nt, Ire Mide: E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Healthcare Consultant permit. Page 1 and 2 should be filed wit Depertment of Health and Montel Hygier Importent: if item 27 is merked other termy injury or other treumetic event, Its once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary B. Ayoub Bishara Elias Hishmeh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7671 Midtown Road, Fulton, Maryland 20759 Samir B. Hishmeh - Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/30/2012 Silver Spring, MD Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. vice Lice 21. Signature of Funeral Se MO124/ 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Day Cardiac/Myocardial Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): 3 Years Examiner Hupercholesterolemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions, if the conditions of the conditions, if the conditions, if the conditions, if the conditions, if the conditions of the conditions, if the conditions of ue to (or as a consequence of) Per 5 Years Obstructive Sleep Apnea Exami ettending physicien and for use es the burial-trensit Physicien: The law requires that the deeth certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) Pregnant at time of death • Hospitel or Attending Physicien: The law requires that the dee Lab hours effect deeth.
• Lane Director: After this certificate has been signed by the entering present of the funeral director, page 2 should be deteched isely filled in by the funeral director, page 2 should be deteched. g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diverticular Disease, Spinal Stenosis, Fibromyalgia, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? History of GI Bleed, Schatzki Ring, Fatty Liver 24a, Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical B Other: 4 🗋 Nursing Home 5 🕅 Residence 6 🗆 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 2 □ No 욛 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 X Natural 2 Accident 5 - Pending 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Signature and title of Certifie November 21, 2012 D0054099

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 12201 Plum Orchard Drive, Silver Spring, Maryland 20904 Kathy-Ann M. Walcott,

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Andrew Cornelius Hosley, Sr. 2012 8:20 Medical 11 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium **Baltimore** Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Country) Maryland Months Hours Min. (Month, Day, Year) 06/01/1953 1 M 2 D F Director 215-60-6223 59 Yrs. : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 ☐ No MDFrederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 Madison Street, Apt. 112 21701 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Yes 2 No Completed by 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 🔯 No Specify: If Yes, Give 3 Widowed 4 TyrDivorced Specify. Year or Dates Black 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) end Mental Hygiene, Is marked other tha Did Not Work N/A Be permit. Page 1 and 2 should be filed Department of Health end Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 2012 Leon Hosley, Sr Ida Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NOVEMBER 25, Lisa E. Wright / Daughter 934 NE 21st., Street, Oklahoma City, GK 73105 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/27/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): use as the burial-transl To the Hospital or Attending Physiclan: The law requires that the death certificate be executed ettending physician end resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Year page 2 should be detached signed by the 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ANDREW 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Woknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las l perform After this certificate 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 NO Other (Specify) HOSPICE 1 Yes 2 X No မူ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🛛 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature ar Chitle of 29c. License number 29d. Date signed; (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. 2300 DULANEY VALLEY RD. MORGAN, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Month Physician/ **Ann Meredith Honia** 802 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITA ALTIMORE 4GNES 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. nth, Day, Year) Dec 17, 1925 100-20-2253 86 VA Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Funeral Director MD Howard Elkridge 1 🗌 Yes 2 🇷 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6393 Beechfield Ave 21075 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baftimore, Maryland 21215-0036 2 No 1 Yes If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Dhito 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) **Music Teacher Higher Education** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ **Timothy Buckley** Earlene Burrus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6393 Beechfield Ave Elkridge, MD 21075 Meredith Ann Lowman 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Nov 28, 2012 Port Washington, NY Nassau Knolls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ature of Funeral Service 23a. Part 1. 2 mer the dis Ast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final UBDURAL HEMATOM.4 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 1ZURE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) STROKES YRS use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy death? 2 🗌 No Yes **Division of Vital** funeral director, Be 25. Was case perered to medical 26. Place of Death (Check only one) examine ? Hospital Other: 2 No Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Manne of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) iniury atural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifying Nursa Practioner: To the best of my knowledge, de

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANJUL SHARMA 900

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death H1 8304 Physician/ Month BEYO 8:20 NOVEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 209-10-6399 1 50M 2 🗆 F 09/18/1918 PAUsual Residence of Decede 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be nottfled at</u> 10b. Count 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 🗆 Yes 2 😾 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 3306 LEE COURT USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give \$ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. and Mental Hygiene. is marked other than "natural", 3 XWidowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) U.S. POSTAL SERVICE POSTAL CLERK of Haalth and Mental Hygic of Health and Mental Hygic Fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HELEN CITRON LOUIS HIRSCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA KOLODNY-HIRSCH/DAUGHTER 3306 LEE COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 5 1 K Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) 11/28/2012 OWINGS MILLS, MD SINAI CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician, TOCK Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Inderlying Examiner this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2/ No 1 🗌 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 2 No 1 Inpatient 2 PER/Outpatient 3 I DOA 27. Manner of Loth 28a. Date of injury / (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Not Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ymsican. Myendina 30. Name and add s of person who completed cause of death (Item 23a) (Type, Print) N. CHARUF BAT. 21200 JOHN 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38278 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month H. JENNINGS 7:23 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of BALTIMORE university Mawland 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) Months 230-56-7512 **Director** 1 M 2 F show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Funeral Director 28a-f 1 Ves 2 No altimore or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Catherine USA 21217 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify. 6116 Specify: "natural" Completed 3 Widowed 4 Dolvorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) onstruction Worker onstruction of Health and Mental Hygi item 27 is marked other other traumatic event, I Be 17. Father's Name (First, Middle, Last) ဂ္ Wilbert Jennings 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 N. t of Health a Marie Jennings Hinton Parrish 20b. Place of Disposition (Name of cemetery, cremative) or other p 20a. Method of Disposition Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important If any injury or Newport News, VA Greenlawn 1 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Vaugho C. Greene Vauch C Bailto. MD. 21279 6151 Balto MO07391 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SCPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 5 days compartment Syndrome AbdOMINA Sequentially list conditions, if any, leading to miniedrate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a conseque the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Day igned by the at be detached for signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HIV page 2 s autopsy performed? Yes 2 No hours after death. Ineral Director; After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a the Hospital Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 215203302

State

ltimore

Andrea Levine

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St

32. Registrar's Signature

orreeve

31. Date filed (Month, Day, Year)

NOV 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOPKINS 8. Date of Birth If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) Country) 32-907 Min. Director 1 **M** M 2 □ F å Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Divorced Completed ac 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) orKer Be other traumatic event, 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, should be file and Mental H is marked of ပ္ 19a. Informant's Name/Relationship (Type, Pant) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is eny injury or other trau imure MD2/213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of preferry, crematory or other) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Vaughn C. Greene Funeral 23a. Part 1. Enter the usclase, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between metastatic Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I d be det 23e. Did tobacco use contribute to the cause of death? à Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t autonsy After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** To Be 26. Place of Death (Check only one) examiner? 2 MNo 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide 5 Pending injury work? ours after death. leral Director: Af filled in by the fu 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined in 24 hour.
in 24 hour.
io the Funeral Directory filler. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) o ley 9 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:22 2012 Jazmine Annissa King 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University Of Maryland Medical Center Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours (Month, Day, Year) 07/25/1996 Country) Florida Director 1 □ M 2 🖄 F 594-61-4593 16 Yrs. Usual Residence of Decedent should be filed within 72 moust and Mental Hygiene.

I and Mental Hygiene.

I be marked other then "naturel", or items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 1X Yes 2 No MD Perryville Cecil 굽 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 337 Elm Street, PO Box 4 21903 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates. Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student B 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kristiann Rouselle <u>Zenovia King</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh Department of Health ar Importent: If Item 27 Is eny Injury or other treu Kristiann Rouselle / Mother 337 Elm Street, PO Box 4, Perryville, MD 21903 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/26/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall & Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Ruptured Cerebral Aneurysm Medical Due to (or as a consequence of): Examiner Subarachnoid Hemorrha e Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ettending physician end for use es the burial-transit or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury <u>Stroke</u> that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) signed by the e 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signer; pege 2 should be d Severe Vasospasm 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 25. Was case referred to medical examiner? BB 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

nerel Director: After this
y filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours af To the Funerel Discompletely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) H 67019

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 2 9 201

Samuel M. Galvagno, Jr. D.O.Ph.D. 22 S. Greene Street, Baltimore, MD

32. Registrar's Sjgnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month emieux Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL **SEVERN** 1797 SEVERN HILLS LANE 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Min Hours **Director** 219.62.5272 1 M 2 XXF Usual Residence of Dece APRIL 30, 1954 MD 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No **ASHTABULA ASHTABULA** OH ъ 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? items 23a Funeral 1931 E. PROSPECT # 511 44004 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or <u>ک</u> 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4xx Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) FINANCE DEPT. PUBLIC EMPLOYEE Be Department of Health and Mental H
Important: If item 27 is marked ott
any injury or other traumary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ANTHONY PUCIATO ANNA KRAUSHOFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER 1797 SEVERN HILLS LANE SEVERN, MD 21144 **ELIZABETH HARGADON** 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State BAYVIEW CREMATORY INC 4 ☐ Donation 5 ☐ Other (Specify) 11.20.2012 BALTIMORE, MD 21. Sign wretef F neral Service (ico 22. Name and Address of Facility
FINK FUNERAL HOME P.A.
426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 Part 1. Enter the disease, or co shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC LUNG CANER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Kother Specify) Other: 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 29a. Certifier Macertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 14774 811) 11-20-12 445 Defense Highway Amnapolis, MD 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID AZIZ H.D 31. Date filed (Month, Day, Year) 37. Registrar's Signature State NOV 29 Registrar

12-08943 Russell Lewis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ussell Lewis		amend #39ate Por Maryland 3 Department of Health an	d Mental H	ygiene		
		1- For State Certificate of Death		Reg.	No. 20	2 38287
Physicia Medical Examii		110301		2. Date of Death Month D November 2		3. Time of Death 1844 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Good Samaritan Hospital Baltimore	Location of Death	1	4c. County of Dear	11
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	ar If Under 24Hrs	8. Date of Birth (irthplace (State or
Director		218-19-9775 1XM 2 F 24 Yrs. Months Day	s Hours Min	2/2/	1988 Fore	ign ountry) / / /
		Usual Residence of Decedent		10/0//	100	1017)
м апу		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once,	ģ	MD NA Baltimore		T.o.		1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number 10f. Zip Code 10920 MCClean Blvd. 212	211	10g.	Citizen of What Cou	untry?
ath the N s 23a or		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi		pecify Yes or No-	14 Race - Ame	rican Indian, Black,
eath v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No			White, etc.	risari fidiari, bidok,
	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	specify:		Specify: Blo	ick
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she c event, the Medical Examiner must be notified at once		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa			6b. Kind of Business	/Industry
36 in 72 l	Bet	Elementary/Secondary (0-12) College (1-4 or 5+)			11/1	
5-0036 led within 72 tygiene. other than 'the Medical	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Mai	den Surname)	
	Be	Russell Lewis II	Sandy	a Roge	rs	
imore, MD 2121 Pages I and 2 should be fi nent of Health and Mental hant: If item 27 is marked or other traumatic event,	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	et and Number or	Rural Route Numbe	r, City or Town, Stat	e, Zip Code)
MD nd 2 sho alth and m 27 is		Jasmine Lewis-Wife 1930 McCled	in Blud	· Baltina	-1	21234
ore, MD 2 es 1 and 2 shoul of Health and N If item 27 is n ther traumatic		20a. Method of Disposition 2 Cb. Place of Disposition (Name of ce crematory or other place)	metery, 12/1	L 1//2012 ²	Oc. Location - City o	r Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify: Bayview Crema	tory 101	3/2012	Daltimos	e, MD
Baltimo permit. Page Department of Important: iojury or otd		21. Signature of Funeral Service Licensee 22. Name and Addres	s of Facility	March	TH-Eas-	10 212 02
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying	, such as cardiac o	or respiratory arrest,	shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Contact Gunshot Wound of Head				Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):				
5. J.M.	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		cause. Enter Underlying Cause (Disease or injury that initiated				
cuted and transit	Examiner	events resulting in death) Last Due to (or as a consequence of):				
9 "	dical	UNPENDED . AMENDED				
d sign	w	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
ox 6876(eath certificate a attending phys for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregna	ancy	Month	Day Year
Box 6876 death certificate the attending phy of for use as the b	Sic	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown				Į.
that the de detached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
cords, P.O. Iaw requires that it has been signed by 2 should be detach	d b			1 Yes	2 ✓ No 3 🗌 Pro	obably 4 Unknown
rds requi	Completed			24a. Was an autopsy		utopsy findings available completion of cause of
ecol he law ate has	티			performe		
Vital Rec hysician: The l this certificate b	0		e of Death (Check			
Vit hysical this c		examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	Other Nursin		sidence 6 Othe	ər:
n of \ding Ph		Month, Day, Year)	ury at Work?	28d. Describe how Subject shot s	v injury occurred elf	
isior Attend or death rector: by the	Cati	2 Accident Investigation	Yes 2 ✔ No			
Division of Vital Records, pital of Attending Physician: The law require ours after death. seral Director: After this certificate has been signed in by the funeral director, page 2 should b	Certification	3 V Suicide 6 Could not be determined (Specify) Grassy area behind house	building, etc.	or Town, State		tural Route Number, City
Hospid 4 hour Funer ely fill		29a. Certifier	ate and place and			
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	edical	(Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and of anner stated.				
F 3 F 8	₹	29b. Signature and title of certifier 29c. License	se number	2	9d. Date signed (M	onth, Day, Year)
2		0.c.	M.E.	1	November 25, 2	2012
UUME		30. Name and eddress of person who completed cause of death (Item 23a)	0			
		Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore 31. Date filed (Month, Day, Year) 32. Figistrar's Signature	e Street, Baltii	more, MD 2122	23	
Sta Regist	-11	NOV 2 9 2012 Leven A. Carlet				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mor Day Physician/ Bessie 8:55 7 Lowery 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice Randallstown If Under 1 Year I If Under 24 Hrs. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) 422-60-5231 68 **Director** 1 🗆 M 2 🗓 F AT. 6-20-1944 Usual Residence of Dece 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore n/a 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21229 USA 3714 Granston Avenue should be filed within 72 hours after death vand Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpeciAfrican-American Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Harlen Park Pharmacy Pharmacy Tech 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ John Henry Allen Lola Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Thomas E. Lowery/Son 8000 Carlson Lane, Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest veterans 12-10-2012 Owings Mills, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Ligenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death CardioThrombotic Erent Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Disease Atheroscierotic Cardiovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine anding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed2
Yes 2 No death? certificate 1 Yes 2 🗌 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother Specify 1 Yes 2 100 ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ceptifier ns/lajupuhemo 29d. Date signed (Month, Day, Year) 11/24/12 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSRAJUPUKJEMO 2835 SMITH AV 5703 Baltomore MO ZIZOG 31. Date filed (Month, Day, Year) NOV 2 9 2012 32. Registrar's aignature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2 Day 2 6 Physician/ Month 1505 150A 13e11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ Maryland shick Tranma Ballimore Mp If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Director 214-22-0719 86 1 🕱 M 2 🗆 F Oct. 28. 1926 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🙀 No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6432 St. Philip Rd. 21090 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Wes, Give
Year or Dates. WW II Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store 12 Meat Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Lehnert Katherine Sachs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Frost 299 Regency Circle, Linthicum, MD 21090 (Grandson) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 11/30/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final hemirrha Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner myoundial mehan Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Examine Dan to (S) as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No EXAMINER Day Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying case given it. is a 1. Least 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CERTI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examine? Other: 2 No မ 1 🗌 Inpatient 2 🗹 ER/Outpatient 3 🗌 DCA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending Natural ,26 715 2 🗤 No wet swnek 2 Accident Investigation 24 hours after death e Funeral Director: Suicide 6 Could not be 28e. Lace of Figury - At home, farm, street, factory, office building, etc. (Speqify) 8f. Location (Street and Number or Fural Route Number, Gity or Town, State) NU 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature

State Registrar

DHMH 17 Rev 06-2011

s. breene St

ss of person who completed cause of death (Item 23a) (Type, Print)

ZMIN

31. Date filed (Month, Day, Year)

EVINI

12-08	3958	
John	Mitchell	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nn Mitchell		State of Maryland / Department of H 1-For State Certificate of D Registrar		ygiene Reg.	No. 2012	38285								
Physicia edical Examin	-	1. Decedent's Name (First, Middle,Last) John Mitchell		2. Date of Death Month D November 2		3. Time of Death 1150 hrs								
			city, Town, or Location of Death altimore		4c. County of Death									
Funeral Director			Under 1 Year If Under 24Hrs Months Days Hours Min.		(MM/DD/YYYY) 9. Birth	place (State or								
ом япу		Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 X Yes 2 No								
he Maryland or 28a-f show any tifed at once.	Director		of. Zip Code 21218	10g.	Citizen of What Count U . S	ry?								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	uneral	1 Never Married 2 Married Armed Forces? If Yes,	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.									
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Completed	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	Nursing	Home								
2121; uld be fil Mental F marked	To Be	Walter Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	Helen A		er, City or Town, State,	Zip Code)								
MD sho rath and 2 sho salth and 2 sho rem 27 is raumati	_	John Michael Mitchell (Son) 4404 N	John Michael Mitchell (Son) 4404 Marble Hall Rd. Apt. 302 Balto., I 20a. Method of Disposition (Name of cemetery, 10ate 20c. Location - City or Town, State											
Baltimore, bernit. Pages I an Department of Hee Important: If itee		1 Burial 2 Cremation 3 Removal from State crematory or other On-Site C1	Baltimore	, MD										
Ball permit Depart Impor		21. Signature of Funeral Service Licensee 22. Nam 21.	音智的が音響をWindwi 40 N. Fulton	n Jr. F	uneral Ho alto., MD	me PA 21217								
Physician Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line. Immediate Cause (Final disease a. Head Injuries	node of dying, such as cardiac o	r respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and Death								
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.												
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last												
executed an and all - transit		d.												
60, ate be ex hysician te burial	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery									
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal c 4 Pregnant at time of death 5 Other	leath 3 Ectopic pregna (Specify)	ancy	Month D	ay Year								
P.O. Es that the igned by the detached	ā	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		acco use contribute to t									
Division of Vital Records, ral or Attending Physician: The law require is after death. **I Director: After this certificate has been sived in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	Completed			24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of								
in: The	Be Co	25. Was case referred to medical examiner?	26.Place of Death (Check	1 Yes 2	No 1 ✓ Yes	2 No								
n of Vit ding Physic L. After this c	္	1 Yes 2 No Indigent 2 ER/Outpatient 3		ng Home 5 Re	esidence 6 Other:									
tending Pl death. tor: After	ation	1 Natural 5 Pending FOUND: Nov 25, 2012 1130 hrs	1 Yes 2 ✔ No		I down a flight of s	stairs								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, st	actory, office building, etc.	or Town, Stat	reet and Number or Rur ite) ne Avenue , Baltimo	•								
o the Ho ithin 24 l	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.												
H S H S	Ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mon November 26, 20									
6		30. Name and address of person who completed cause of death (Item 23a) Pamela F. Southall, MD. Assistant Medical Evaminar, 200 M	/ Baltimore Street, Balti											
Sta		31. Date filed (Month, Day, Year) 31. Registrar's Signature												
Regist	rar	NOV 2 9 2012 Comm p. Jane												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	aryland /	-	rtment o				iene _{eg. No} 20	112	382	286
Physicia	n/	Decedent's Name (First, Middle, Last PATRICIA MARIE MANN	and the						2. Date of Deat Month NOVEMBER	h		3. Time of 8:17	Death P M
Medic Examin		4a. Facility Name (if not institution, give				4b. City, Tow		n of Death	HOVEPIDER	4c. Count	y of Death		
Funeral		1611 MANNING RD. 5. Social Security Number 6. S	ex 7. Age	e (In yrs. last b	irthday)	If Under 1 Y		ler 24 Hrs.	8. Date of Birth (Month, Day,		9. Birth	place (State o	r Foreign
Director		216.28.3418 1 Usual Residence of Decedent	☐ M 2 XX F	83	Yrs.	MOUNTS	iys Hours	S IVIIII.	APRIL 22		Cour	MD	
land show dat	tor	10a. State 10b. County		10c. City, To	wn or Loc	ation						10d. Inside Ci	ity Limits
e Mary 7 28a-1 notifie	Director	MD ANNE ARU	NDEL	GLEN B	URNIE	1407 71 0							XX No
with the	eral [10e. Street and Number 1611 MANNING RD.				10f. Zip Co	² 21061		1	l0g. Citizen of US		intry?	
(and 21215-0036) be filed within 72 hours after death with the Maryland antal hygiene. ked other than "natural", or items 23a or 28a-f show c event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give			/as Decedent Yes, specify (of Hispanic C Suban, Mexic		cify Yes or No- Rican, etc.)	14. Ra	ce - Americack, White,	etc.	
nours a	Completed	3 Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates. ducation			ent's Usual Od			Т	16b. Kind of E	MHI		
215 liin 72 l le. han "n hedi	omp	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4 or 5	+)	life. DC	nd of work do NOT use reti	red)	ost of worki	ng			radotty	
d 21 ed with Hygien other ti	Be C	9 17. Father's Name (First, Middle, Last)	_		ŀ	OMEMAKE		thor's Nome	/Eirot Middlo A		HOME	_	
Irylanc	10 E	WILLIAM HARRY CUDDY						THER ST	(First, Middle, M ARR	raiden Surnan	ne)		
Ma 22 sh Ith ar Ith au trau	13	19a. Informant's Name/Relationship (7	vpe, Print) DAUGI						Route Number,		State, Zip	Code)	
Baltimore, Dermit. Page 1 and Department of Heal Important: If item: any injury or other		20a. Method of Disposition 1XX Burial 2 Cremation 3		20b. Place	of Dispos	ition (Name o	F	r		20c. Location	- City or T	own, State	
timo t. Page tment tant: I		4 Donation 5 Other (Speci	2			EMETERY		11.21.2	012	GLEN B	URNIE,	, MD	
Bal permi Depar Impol any in		21. Signatur. f Funeral Service (cer) K. CRECORY FINK	-	1148	FIN 426	Name and Ad IK FUNER CRAIN	Idress of Fac AL HOME -IWY SW	P.A.	RNIE, MD	21061			18
Physician/ Medical Examiner		23a. Part 1. Let the disease, of common shock, or heart failure. List only of mediate Cause (Final disease or condition resulting in death)	a. Rer		Fao	the mode of		as cardiac o	r respiratory arre	st,		Approximat Interval Bet Onset and	ween Death
be executed sician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events resulting in death) Last	b. Due to (or as a										
Box 687 death certifica he attending p hed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Fetal dea		Ectopic preg Other (specif					ate of deliv	-	Year
ords, P.O. requires that the been signed by t	by	Part II. Other significant conditions of Alzheimer's	-		g in the ur	iderlying caus	e given in Pa	art I.		es XX No			
HeC	Completed								24a. Was ar autops perforr 1 Yes	med?	Were auto prior to co death? 1 \(\subseteq Yes	ppsy findings a ompletion of c	available ause of
ital sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:				6. Place of D		only one) XX me 5 L Reside				
Of V g Phys er this reral d	te: To	27. Manner of Death	1 ☐ Inpation 28a. Date of injue (Month, Day)	ent 2 ER/0	. Time of	28c.	njury at		me 5 L. Reside 28d. Describe ho			y)	
DIVISION Of VITAI RECORDS, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should the completely filled in by the funeral director, page 2 should the completely filled in by the funeral director, page 2 should the completely filled in by the funeral director, page 2 should the completely filled in by the funeral director, page 2 should the completely filled in by the funeral director.	Certificate:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ıry - At home,	injury farm, stre	М	vork? I Yes 2		28f. Location (Str City or Town		ber or Rura	al Route Numb	per,
Die Hospital	Medical	(Check 2 L Medical Exam	sician: To the best of iner: On the basis of ease Se Practitioner: To the	kamination and	or investi-	gation, in my c	pinion, death	occurred at	the time, date an	d place, and d	ue to the ca	ause(s) and ma	inner stated.
To th withi To th		29b. Signature and title of certifier	2 Kin	emo.			ense numbe	r	. 2	9d. Date sign		Day, Year)	3
V		30 Name and address of person who RIVERA KING, MD 120	completed cause of d	eath (Item 23a) (Type, Pr	int)	340904			1 Youen	VIII .	-1,211	
Stat Registra	le ar	31. Date filed (Month, Day, Year) NOV 2 9 201		ula Cianastona									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b, perFH, G933, 11729/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NoWorth 26,20912 Physician/ Year 9:25p Veldai Mims Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Sykesville Transtion Health Care Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** MD Country) (Month, Day, Hours Min. 1 M 2 X F Months 220-78-1870 48 I'964 **Director** Aug Usual Residence of Decedent 28a-f show 10b. County Baltimore 10d. Inside City Limits Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Reisterstown 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 6401 Deer Park Road 21136 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc Black Specify: ģ "natural", or 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 N/A0 N/A N/A other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Henry Mims Caryann Hubbard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode)

Reisterstown, MS 19a. Informant's Name/Relationship (Type, Print) Darrell Mims/Brother 21136 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place.
Metro Crematory 1 Burial 2 **Cremation 3 ** Removal from State any injury or 11/30/12 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly 2700 Edmondson Ave. Balto., MD 21223 Signature of Funeral Service Licensee and Sheer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ e reb disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami and I-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 Unknown ed by the a detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nin 24 hours after death.

the Funeral Director: After this certificate handleted filled in by the funeral director, page performed death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending work 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

1300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ent's Name (First, Middle Last) 2. Date of Death Physician/ eaurin November 7:20 PM 2012 Medical 4a. Facility Name of not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ballimore Hospital of Ballimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-52-707 63 Director 1 🗆 M 2 😿 F Department of Health end Mental Hygiene, imprortent; or items 23e or 28e-f show importent: if item 27 is marked other then "naturel", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Examinar must be notified at once. Once. Page 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Health end Mental Hygiene. ent If item 27 is marked other then "naturel", or items 23e or 28e-f sho 10b. County City, Town or Location 10d, Inside City Limits Director baltimore 1 Yes 2 No 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 WYNNS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Completed by 1 Never Married 2 Married 1 Yes 2 No Yes. Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) a years Be Name (First, Middle, Cast) ျှ Known as a. Informant's Name Relationship (Type, Pri Number, City or Town, State, Zip Code) 21216 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service License 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner > 5 years mnic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 1 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident
3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) November 25, 2012 Ocon. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore 31. Date filed (Month, Day, Year) 37 Registrar's Signatu Registrar

atient

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Benson James Mwangi 2:09 AM NOVEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE CITY AUK HOSPITAL OF If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 219-86-1082
Usual Residence of Decedent 1 🔀 M 2 🗆 F 55 May 09, 1956 Kenya or then "natural", or Items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 No Baltimore MD 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21216 2903 Allendale Rd. Kenya. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 No Specify. specifyBlack Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) yrs Electrical Engineer Private Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked o မ Phyllis Wanuyu Kabuga Mwangi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 2903 Allendale Rd. Baltimore, MD 21216 Musau T Shinanga/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) _20c.Location - City or Town, State Karindundu Karotina permit. Page 1
Department of Importent: If it any Injury or of once. D Burial 2 ☐ Cremation 3 ☐ Removal from State The Family Kabuga 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facilit Chatman & Harris Funeral Hm. 5240 Reistertown Rd. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner SMALL CANCER CELL GUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burlal-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year a | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an within 24 hours after death.

To the Funerel Director: After this certificate I completely filled in by the funeral director, pagn performed? Yes 2 🗹 death?
1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signatu and title of certifie 29d, Date signed (Month, Day, Year) Mb ES-000 24, 2012 NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE KAHU 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

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PATIENT KNOWN AS:

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 335 Medical 2 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 06/30/1929 Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours ^{Country)} South Africa 1₹ M 2 □ F 067-30-5225 Director 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours aftar daath with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No MD Anne Arundel Annapolis ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 570 Bellerive Road, Apt. 236 21409 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, I Hygiane. other than "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Page 1 and 2 should ba file ment of Health and Mental I ant: If Item 27 is marked c Cyril Madden Marjory Ellery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Margaret Madden / Wife 570 Bellerive Road, Apt. 236, Annapolis, MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 11/26/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota <u>Marshall</u> hall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ entricular Tochycard disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner nyocard Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ours aftar death.

erel Director. After this certificate has baen signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit. Exami Hospital or Attending Physician: The law raquiras that the daath carlificeta ba executad that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funerei D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. complataly Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 06 27 2012

State Registrar PArhway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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/32. Registrar's Signature

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31. Date filed (Month, Day, Year) NOV 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0938AM Gene H. Modlin Medical 2012 Examiner Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death : Sbur HIP OM Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/03/1939 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Country) Unkn. Director 1 ØM 2 □ F 212-36-6467 73 Usual Residence of Decedent parmit. Paga 1 and 2 ehould be filled within 72 hours after death with the Maryland Department of Health and Mantal Hyglane.
Importent: If Item 27 is marked other then "netural", or Items 23e or 28e-f aho amy injury or other treumatic event, the Medical Examiner must be neithed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Andrews Street 21643 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Narried Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Annie May Stalls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georganna Modlin / Wife 102 Andrews Street, Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/29/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Down Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Onset and Death MALIGNANT CARCINOMA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the attending physician and thed for use as the burlai-transit or Attending Physician: The law requires that the death cartificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month elgnad by the a Day q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ To the Hospital or Attending Proystoten: 11th 12th hours after death.

To the Funeral Director: After this certificate has been el completely filled in by the funeral director, page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\square\) No 1 🗌 Yes 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICER 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred □ Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 2/102 WARY BO 8

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:40 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner RINCE GEORGE'S MANOR II LIZABETH LANHAM 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2 2 F Months Days Hours Min Month Da Day puntry) 230-12-3002 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** DC WASHINGTON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or QUINCY STREET 2725 20018 U5A and Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şeconday (0-12) College (1-4 or 5+) GOVERNMENT XAMINER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHAUTAUGUA AVENUE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State VANTICO NATIONAL 30 4 Donation 5 Other (Specify) 22. Name and Address of Facility BIANCHI Signature of Funeral Service License FUNERAL H01251 TUR STREET NOW WASHNETON DC 20011 23a. Part Lenter the disease, or complications that caused the death. Deshock, or heart failure. List only one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) **Examiner** Sequentially list conditions, it ary, leading technique cause. Enter Underlying Physician/Medical Examiner Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Worknown Division of Vital Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No this certificate apleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. 28c. Injury at work? Manner of Death 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗆 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Homicide 24 hours Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signat \$ 226 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 8116 Good Luch

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38294 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O'Neill 40 James 2012 Medical 11 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death FRANKLIN SQUARE Hospital Rosedale Baltimore 8. Date of Birth (Month, Day, Year) 07/15/1935 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-34-2700 Usual Residence of Decedent Director 1 🗶 M 2 🗆 F MD 77 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4809 Mannasota Avenue U.S.A. 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 nem 27 is marked other than "natural", other traumatic event, the Medical Exal Year or Dates. 1958-60 1 Yes 2 X No Specify Specify White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Lineman/Installer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည O'Neill Marie Stump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health ai Important: If item 27 is any injury or are Nannette O'Neill, Wife 4809 Mannasota Avenue, Baltimore, MD21206 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. | 12/03/2012 | Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Clerendua 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cancel Lung MONTHS disease or condition resulting in death) Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): executed that initiated events Due to (or as a consequence of): physician are the burial-t resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Unknown the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page performed' certificate 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director, After this etely filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident work 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 3 _ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D.51555 11-28-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10x1 FRANKLIN SQUEER DR Balto md 21237 Aung SEIN 4000 31. Date filed (Month, Day, Year)

Registrar

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П	Funeral		5. Social Security Number (e (In yrs. last	birthday)	If Under 1 Year	If Under 24 I	Irs. 8. Date of Bir		g. Bir	thplace (State or Foreigi	n	
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	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Funeral	1725 Braddish			21216				U	.S.A.			
	dea r itel		11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	· ·	 Race - Ame Black, Whit 			
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and										ause(s) and	d manner as st	ated.	-	
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	KA		30. Name and address of person wh	o completed cause of de	ath (Item 23a	a) (Type, Pr					1,1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Kathryn Patrick November 27, 2012 2:30 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Greater Baltimore Medical Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Sept. 10, 1929 Baltimore, MD. 218-26-4870 83 Director 1 □ M 2X F Yrs Usual Residence of Deceden 2 should be filed within 72 hours after death with the Maryland th and Mentel Hygiene.
27 is marked other then "neturel", or Iteme 23e or 28e-f show treumetic event, the Medical Examinar must be mutiled at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore County Maryland Reisterstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21136 United States 4801 Piney Grove Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Specify: Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) 04 Public Schools 12 Elementary School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thomas Edgar Shamberger Mildred Evelyn Keys 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s if Health a Item 27 i Mrs.Mary-Beth Yachimowicz 4801 Piney Grove Road Reisterstown, MD. 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Harford County Forest Hill, Maryland Depertment of H Importent: If ite eny injury or ott once. Friday Nov.30,2012 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State Evens Funeral Chapel and Cremation Services, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Consedeffrey L. Gair, Sr., CFSP22 Name and riddings of Facility ves Funeral and Cremation Center, P.A.

1. July 1. Gair, Sr., CFSP22 Name and riddings of Facility ves Funeral and Cremation Center, P.A.

2325 York Road Timonium, Maryland 21093–2215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ er disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ettending physicien and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month is certificate hes been signed by the edirector, page 2 should be detached g Unknown P.O. Part II. Other significant conditions contributing ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes or Attending Physicien: The 2 No 1 Tes 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Vatural 2 Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funeral D completely filled it Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year) mille 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN S, Meltzer, M.D. Ø TMON

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23apt. II 25 per me g933 11-29-12 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month PM 3:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Enrore Ellicott Howard If Under 24 PM Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) . Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) Jul 18, 1929 020-22-5362 83 MA Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City, MD 1 Yes 2 TNo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3110 Hayfield Drive 21042 U.S.A. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Yorkan Year or Dates War Era Completed by Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leonard E. Peterson **Beatrice Crockett** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Peterson Wife 3110 Hayfield Drive Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot Date 1 Burial 20 Cremation 3 Removal from State Atlantic Crematory, LLC Nov 28, 2012 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li-22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. 23a. Part 1 Interval Between Immediate Cause (Final Onset and Death Physician/ metastases disease or condition **4edical** resulting in death) ∡aminer Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events ROVED BY MEDICAL After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 🗌 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SP CABG. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 - No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 2 No Hospital: Other: 1 X Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c License number 30. Name and address of pe erson who completed cause of death (Item 23a) (Type, Print) Giddina s Whitaker Melissa 9715 Healt 31. Date filed (Month, Day, Year) NOV 2 9 20 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38298 State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 3:30 A M Prevost November Alphonse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice
Social Security Number 6. Sex Timonium Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 219-16-3905 1 X M 2 □ F 88 Jan 22, 1924 Maryland Usual Residence of Deceden 28a-f shov 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛛 No Maryland Towson Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8108 Bellona Avenue 21204 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No 3 Widowed 4 Divorced Specify Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Maryland State Elementary/Secondary (0-12) College (1-4 or 5+) 12 Docket Clerk Court System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Prevost Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta A. Prevost/Sister-in-law 16 Hewetson Court, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 11/29/2012 Baltimore, Maryland ner f Funeral Service Licensca 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. Bryan W. Clary 10 W. Padonia Road. Timonium, MD 2109 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cadse (Final Approximate Onset and Death Pnysician/ ALZHEIMER'S DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): physician and is the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending is the Funerel Director after this certificate has been signed by the attending is the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE မှ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed caus 2300 DULANEY VALLEY RD. TRACIE -L. MORGAN, CRNE TIMONIUM, MD 21093 State

Registrar

NOVEMBER 26.

ALPHONSE PREVOST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Francis Arthur Parru 2:50 p M 2012 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1000 Downs Drive Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days 578-05-6556 Director 1 X M 2 □ F Yrs 92 New York 12/30/1919 show 10a. State 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland Silver Spring 1 Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Downs Drive 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Completed 3 Divorced WWI1 Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Intelligence Officer Federal Government Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, ODGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pierce Arthur Parry Rose Angela Sweeneu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn P. Koenig - Daughter 13760 Triadelphia Mill Road, Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 11/28/2012 | Silver Spring, MD 4 Donation 5 Other (Specify) . Signatur 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Funeral Service Light 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, the attending physician and the for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Director: After this certificate Yes 2 X N 24 hours after death.

Funeral Director. After this certifical letely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) D47928 November 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila M. Bahadori, M.D., 10301 Georgia Avenue, #304, Silver Spring, Maryland 20902

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) NOV 2 9

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	_ State	ate of Maryl		artment of H tificate of D			2012	38300			
			1. Decedent's Name (First, Middle, Last) 2. Date of Death										
	Physicia Medic		Evelyn L. Preissler	24, 2012									
	Examin	er	4a. Facility Name (if not institution, give street a 331 2nd Ave	nd number)		4b. City, Town, or Lansdown		1	,	4c. County of Death Baltimore			
ı	Funeral Director		5. Social Security Number 218–36–6959 6. Sex	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth March 1	Year) 1941 9. Bii	thplace (State or Foreign wptry) Maryland			
	show d at	tor	Usual Residence of Decedent		. City, Town or Loc					10d. Inside City Limits			
	or 28a-f	Director	10e. Street and Number	Lansuo	10f. Zip Code		1	0g. Citizen of What Co	1 ☐ Yes 2 ☐ No				
	n with the same is 23a onust be	Funeral	331 2nd Ave.			21227		USA					
9800	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	1 Never Married 2 Married 1	as Decedent Ever in med Forces? Yes 2 4No Yes, Give ar or Dates.	lf	Vas Decedent of His f Yes, specify Cubar	n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:				
215-(n 72 hou an "nati Medica	mple	15. Decedent's Educatio (Specify only highest grade con Elementary/Seconday (0-12)		(Give k	lent's Usual Occupa kind of work done d D NOT use retired)		king	16b. Kind of Business	Industry			
121	d within dygiene.	0	9th 17. Father's Name (First, Middle, Last)	nege (1-4 of 54)	Elec	trical Wo			Lighting				
/lanc	ould be filed nd Mental Hy marked oth imatic event	To B	Glen Wilkerson, Sr.				18. Mother's Nar Ruth Ho	aalden Surname)					
Maryland 21215-0036	of and 2 should be of Health and Mente of Health and Mente of item 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, Pri. James Younger, son	nt)	19b. Mailin 645	g Address (Street a 9 Colonia	nd Number or Ru 1 Knoll	ral Route Number, Glen Bur	City or Town, State, Zinie, MD. 2	1061			
Baltimore,	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Remoder 1 □ Donation 5 □ Other (Specify)	I 6 Chaha	b. Place of Dispos cemetery, crem Meadowri	sition (Name of natory or other place dge Memor	ial Park		20c. Location - City of 012 Elkri	Town, State			
Balt	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee	3.		mbrose ^{Ad} fü 719 Hammo			nsdowne nsdowne, M	D 21227			
Г			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus							Approximate Interval Between			
	Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con:	neum	ms	Si Si			Onset and Death			
Same and	Examiner	je.	Sequentially list conditions, b. —		Tarco	nom	fung			6 money			
	uted d ansit	Examine	if any, leading to immediate cause. Enter Uniderlying Cause (Disease or linjury that initiated events c	Due to (or as a con:	sequence of):								
0	ate be executed bhysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a con:	sequence of):								
8760	tificate ng phy: as the	Medi	IF FEMALE:										
Box 687	r requires that the death certifica been signed by the attending p should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pre Live Birth 2 Pregnant at time Unknown	у		23d. Date of de Month	elivery Day Year					
ds, P.O.	quires that t en signed b ould be deta												
Division of Vital Records,	The law ate has page 2	Completed by	25. Was case referred to medical						y prior to death?	utopsy findings available completion of cause of			
Vita	ysiciar is certif directo	To Be	examiner? 1 Yes 2 Hospita	il: 1 Inpatient 2	2 ☐ ER/Outpatien	Othe	ace of Death (Che $^{cr:}$ 4 \square Nursing F		ence 6 🗆 Other (Spe	cify)			
ou of	nding Phys ath, r: After this ie funeral di	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	a. Date of injury (Month, Day, Yea	28b. Time of injury	work	rat ? Yes 2 □ No	28d. Describe ho	w injury occurred				
ivisio	I or Atte after de Directo		3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - A building, etc. (Spe	At home, farm, streecify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,			
	To the Hospital or Attending Physician: whim 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Prac	the basis of examin	ation and/or invest	tigation, in my opinio	n, death occurred	at the time, date and	d place, and due to the	cause(s) and manner stated.			
	To the within to the complex c	-	29b. Signature and title of centrier			29c. License	number	2	9d. Date signed (Mont	h, Day, Year)			
			30. Name and address of person who completed	ed cause of death ((Item 23a) (Type, P	Print)	PI	BAL	NMU =	2022			
B	Sta Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEHMAN 2717 Hammanh Ferry Rol BARNMU 2021) 31. Date filed (Month, Day, Year) NOV 2 9 2012 Leven 3. January										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death RUSSELL Physician/ Month Day Year 6:51 SALLIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NORTHWEST HOSPINAL RANDALLSTOWN BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Min. 1 □ M 2 😾 F M2-127-1923 89Yrs. **Director** 216-24-4472 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Catonsville MD. Baltimore 10f. Zip Code 21228 10e. Street and Number 10g. Citizen of What Country? Funeral 1317 Pleasant Valley Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 X No Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Baltimore Citv Department Head 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie McCain Dock Horne any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra C. Russell/ Daughter Department of Health a Important: If item 27 i <u>1317 Pleasant Valley Drive, Catonsville, MD 21228</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of I 1 X Burial 2 Cremation 3 Removal from State 12-1-2012 Arbutus Memorial Park Arbutus ,MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner DAY NEUMONIA Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or imjury Box 6876062 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, ACUTE RENAL FAILURE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an GASTROINTESTINAL BLEEDING autopsy performe Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 **N**o ൧ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Purse Factories: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) Do0 60293 NOVEMBER 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD COURT RD. KANDALLSTOWN MULTURA AHMED M.D. 5401 31. Date filed (Month, Day, Year 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

P.O.

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:45 am Eleanor Robbins 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Valley Nursing Home Rockville Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 💢 F Months Days Hours 82783/1926 579-24-9202 86 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 u.s.A. 2808 Bel Pre Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify. Completed 3 X Widowed 4 Divorced Caucasian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fabric Seamstress other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond Benson Gertrude Fawcett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau. 2808 Bel Pre Road, Silver Spring, Maryland 20906 Jack Lauck Robbins, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Lincoln Crematory: 12/04/2012 Brentwood, Maryland Ft. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 perioditions that cause it one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. List death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ Breas ear disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Live Birth 2 Live a Sound Pregnant at time of death
Unknown Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2√No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 🗌 Yes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Const

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar		State of M	arylaric	Cen	tificate	of D	eaillí a eath	iria iv		Reg. No.	012	38303
ı	Physicia	n/	1. Decedent's Name (t)							2. Date of Dea	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if no		4b. City, Town, or Location of Death				Nov 26, 201		unty of Death	3:40 A M			
أبعرب)	-	Baltimore			n Bur					Arunde	_			
ì	Funeral Director		5. Social Security Num 220-56-8090	e (In yrs. las 59	st <i>birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.		8. Date of Birt (Month, Da Nov 5, 1	fonth, Day, Year)		hplace (State or Foreign untry) MD		
	and show at	or	Usual Residence of I 10a. State 1	Ob. County		10c. City,	Town or Loc	ation							10d. Inside City Limits
	Maryla 28a-f s	al Director	MD	Anne Arun	del	Glen	Burnie								1 ☐ Yes 2 XX No
	a or 2 be no		10e. Street and Numb	er				10f. Zip	Code				10g. Citizer	of What Co	untry?
	th with ms 23 must	Funeral	313 Hospita	l Dr.	40.34/ . D	- : !!0	140.14	$\overline{}$	21061		0.40	7. V N.		USA	
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XXDivorced 12. Was Decedent E Armed Forces? 1 Yes XXII If Yes, Give Year or Dates.				If Yes, specify Cuban, Mexican, Pue				Puerto F	lican, etc.)		Race - Amer Black, White ecify: Whit	e, etc.
5	2 hou "natu edical	plet		15. Decedent's Ed fy only highest gra			16a. Deced			tion uring most o	of workir	g	16b. Kind	of Business/I	Industry
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/lan	d be f Venta arked	욘	Herbert S. I	Bussey							Rose	L. Terry	•		
, Maryland 21215-0036	nd 2 shoul saith and I n 27 is ma		19a. Informant's Nam Tammy Emory		pe, Print) ece	1						Route Numbe e, MD 2		vn, State, Zip	Code)
nore			20a. Method of Dispos	Cremation 3	Removal from State	cer	nce of Dispos metery, crem	atory or ot	her place			ate		tion - City or	Town, State
Baltimore,	permit. Page Department of Important: If any injury or once.	ı	4 Donation 5	ral Service Light	A C	>	iew Cre	Name and	Address	of Facility Home			Daitim	ore, MD	
	20 = 8 0			cry Fink	M0114			426 Cr	<u>rain b</u>	wy S.,	Gle	<u>Burnie.</u>		061	Approximate
	Physician/ Medical	í N	shock, or heart f Immediate Cause (Fir disease or condition resulting in death)		Jeur								Interval Between Onset and Death		
ggar É.	Examiner	L.	Sequentially list cond	litions.	Due to (or as	a conseque	erice or):								
~	ted ansit	Examiner	if any, leading to immo cause. Enter Underlyi Cause (Disease or inj	ing I I	Dué là (or às	a conseque	nce oij.								
0	icate be executed physician and is the burial-transit	sal Ex	that initiated events resulting in death) Las	st	Due to (or as	a conseque	nce of):								
760	icate l g phys	ledical			d										
Box 68	requires that the death certifichers is the detached for use as should be detached for use as	Physician/N	IF FEMALE: 23b. Was decedent pr in the past 12 mc 1 ☐ Yes 2 📈 I 9 ☐ Unknown	onths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 - Fetal	death 3 🗌	Ectopic p Other (spe					230	I. Date of deli Month	ivery Day Year
P.O.	that the ned by tl e detach	by Ph	Part II. Other significa	1		ut not resul	ting in the ur	nderlying c	ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
	law requires nas been sign e 2 should b	ted t	Keys.	ulen.	ion							1 🗆 '	Yes 2 X	No 3 🗆 Pr	obably 4 Unknown
Division of Vital Records,	The lav ate has page 2	Completed	Se	evil								24a. Was autop perfo 1 Yes	sy rmed?	prior to c death?	opsy findings available completion of cause of
ā	Ician: Sertific ector,	Be	25. Was case referred examiner?	i i	Hospital:				26. Plac	ce of Death	(Check				
<u>></u>	Phys r this o	은 [1 ☐ Yes 2 🔼 1 27. Manner of Death	No	1 Inpati		R/Outpatient		Bc. Injury	4 ∟ Nur		ne 5 Resid			(fy)
ono	anding ath. rr. Afte he fun	licate	2 Accident	5 Pending Investigation	(Month, Day	y, Year)	injury	М	work?	es 2□1	- 1	28d. Describe how injury occurred			
DIVISI	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	al Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)											umber or Run	al Route Number,
	n 24 hou n 24 hou ie Funer	Medical	(Check 2	Medical Exami	ician: To the best of ner: On the basis of e e Practitioner: To th	xamination a	and/or investi	gation, in m	ny opinion	, death occ	curred at	he time, date a	nd place, an	d due to the c	ause(s) and manner stated.
	To the within comp		29b. Signature and title	e of certifier	Bulgar	·		29c. License number				29d. Date signed (Month, Day Year) November 26, 2012 Live Suite 298			
	5		30. Name and address			eath (Item 2	23a) (Type, Pr	rint) 37	25 -	KUSP Si=	MA	L DRI BURNI	VE S	PULTE D 210	508
	Stat Registra		31. Date filed (Month,		32. Registra	ar's Signatui	bar						ę		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nov **p.** M 2012 Hattie Belle Staten 2:17 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore ManorCare-Woodbridge Valley Catonsville 7. Age (In yrs. last birthday) 86 yrs. **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 237-52-6345 Months 1 M 2 X Country) **Director** Usual Residence of Decedent should be filed within 72 hours and and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show a marked other than "natural", and items and a marked other than "natural". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore Randallstown MD 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9711 Mendoza Road 21133 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify African - American If Yes. Give 3 😾 Widowed 4 🗆 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 7th Damestic Damestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Estellar Bryant Frank Weeks and 2 should by Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Conyers/Daughter 3414 Tulsa Rd., Baltimore, MD 21207 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of I Important: If ite any injury or ot 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans 12-11-2012 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ERGBROVAS CHIAR disease or condition Medical resulting in death) **Examiner** JENS118 Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of) Due to (or as a consequence of): physician a s the buriat-68760 attending p IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural work? 1 Yes 2 No 5 Pending injury Division To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

P.O.

CENTER

DR: VE

REISTERSTOWN MD 21136

210

32. Registrar's Signature

31. Date filed (Month, Day, Year)

NOV 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 1 2 3 8 3											38305					
	Physicia	rá/	Registrar 1. Decedent's Name (First, Middle, Las	Joanne		2. Date					Reg. No. 1					
and the same	Physicia Medic	al	4a. Facility Name (if not institution, give				Nove					Month vember 27, 2012 Year 10:00 A M				
mer de	Examin	er	2008 Druid Park Drive			Ba1	timore	9		- 1	N/A	Death				
	Funeral Director		5. Social Security Number 216–54–4629 Usual Residence of Decedent		Age (In yrs. Ia 64	ast birthday) Yrs.	If Under 1 Y Months D	ear If U ays Hou	nder 24 Hrs. urs Min.	8. Date of Bi (Month, Da Oct 20,	ay, Year)		I. Birthp Count MD	lace (State or Foreign ry)		
	yland f show ed at	tor	10a. State 10b. County	0b. County 10c. City, Town or Location									1	0d. Inside City Limits		
	or 28a-	Director	MD N/A 10e. Street and Number				10f. Zip Co	Balti de	more		10a C	Citizen of Wha	at Coun	1XX Yes 2 □ No		
	is 23a o	Funeral	2008 Druid Park Drive					1211			, og, e	U.S.A.				
9036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 Never Married 2 XX Married 3 Widowed 4 Divorced	nt Ever in U.S s? X No	lf If	Vas Decedent Yes, specify (Cuban, Me	xican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - American Indian, Black, White, etc. Specify: White					
15-(72 hou n "nati Aedica	nplet	15. Decedent's Ed (Specify only highest gra	de completed)		(Give k	16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)						16b. Kind of Business/Industry			
212	within /giene.	e Cor	Elementary/Secondary (0-12)	College (1-4 c	or 5+)	Printer						Zurich Insurance				
Baltimore, Maryland 21215-0036	ild be filed Mental Hy iarked ott	To Be	17. Father's Name (First, Middle, Last) James Dennis				nther's Name (First, Middle, Maiden Surname) nrietta Yingling									
e, Mar	and 2 shou Health and Mm 27 is m her traum	Donald Spicer (Husband) 2008 Druid Park Drive								ral Route Number, City or Town, State, Zip Code) to, MD 21211						
timore	permit. Page 1 a Department of H Important: If ite any injury or ot		20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	ite C	Place of Disposemetery, cremetery, cremetery	natory or other ematory	place)	12/3		G1	ie, l				
Bal	permit Depar Impor any in	12	21. Signature of Funeral Service License	only		36.	Name and A	ddress of F Road	Balto,	ge e H enss MD 2121	s-Sei l1	tz Fune	ral I	Home, Inc.		
	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each l	ine.						rrest,			Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death)	a. Due to (or a	as a consequ	ience of):	hc- 1	٠. ر					T			
	ped sit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to final ediate cause. Enter Underlying Cause (Disease or injury that initiated events Ceribral Vasuler Disease Due to (or as a consequence of): Due to (or as a consequence of): Corybral Vasuler Disease Due to (or as a consequence of): Corybral Vasuler Disease Disease of injury that initiated events													
	ate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):	<i>-</i>									
3760	ficate b g physias the k	fedical		d									\perp			
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	b. Was decedent pregnant in the past 12 months? 1 Yes 2 No						3 ☐ Ectopic pregnancy 5 ☐ Other (specify)						
s, P.O.	iires that the signed by ald be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								-	/	e cause of death?			
Division of Vital Records,	ne law requ e has beer age 2 shou	Completed by	Chrimic Mis	antenc	Is	chin		145 h	ternan		psy ormeg?	prio dea	r to cor th?	sy findings available inpletion of cause of		
tal R	cian: The		25. Was case referred to medical examiner?		38000			6. Place of	Death (Ched	only one)	24 N	No 1 L] Yes	2 🗌 No		
Į Vi	Physic r this co	욘	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp 28a. Date of in		ER/Outpatien		Other: 4 [Injury at	Nursing Ho	ome 5 Res		6 Other (Specify)			
ou c	anding eath. or: After he fune	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, I	Day, Year)	injury		work?		200. 00301104	now inju	ny occurred				
Divisi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I	njury - At ho etc. (Specify,		et, factory, of	îce		28f. Location (City or To			r Rural	Route Number,		
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check 2 Medical Examination)	ner: On the basis o	f examination	and/or invest	igation, in my o	pinion, dea	ath occurred a	t the time, date	and plac	e, and due to	the cau	se(s) and manner stated.		
	To the within 2 To the comple		29b. Sibnature and title of of tifier	Randy	6/1	0	29c, Lio	3 4L			29d. Da	ate signed (A	onth, E	Day, Year)		
	5 m		30. Name and address of person who c	ompleted cause o	f death (Item	23a) (Type, P	7 3 3 C	ک ہے	+ #1	36 B1	KS	MD	2	21218		
	Stat Registra	_	31. Date filed (Month_Day, Year) NOV 9 9 9	32. Regis	strar's Signat	ture	-17			,						
DIII			1101 10 1	LA CONTRACTOR	WI .	14. 140	4000									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Dorothy Marie Shaw Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ALTIMORE If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min. (Month, Day, Year) Director 228-82-1068 1 □ M 2 🔀 F 60 Yrs. 03/10/1952 Virginia 10a. State 10b. County r than "netural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1723 Langford Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. δ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3

Widowed 4 □ Divorced If Yes, Give Year or Dates Completed Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk 12th grade Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 David Powell Mattie Veneble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 1 end 2 sof Health a item 27 i Quinise Green/Daughter 1723 Langford Road Baltimore, MD. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MD. 12/101/12 permit. Page 1 Depertment of ₽ Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Veterans Cemetery Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore,MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ atherosclerone cardiovaschar disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to infraediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami the attending physician and the for use as the burlel-transit or Attending Physician: The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav To the Hospital or Attending Physician: The law requires that the dee within 24 hours after death

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗹 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** å 26. Place of Death (Check only one) examiner? Certificate: To 2 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, detained place and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number (m) D47353 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Mayland 21229 Catun Avenue rack 900 00

State Registrar 31. Date filed (Month, Lay, Year)

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DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Melissa Brassell, MD

31. Date filed (Mo

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

November 26, 2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #27 Per PHY G933 11/29/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Robert Joseph Saah 7:10 pm November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12609 St. James Road Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 220-28-6377 Director 1 M 2 D F 78 April 15,1934 Washington, DC 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho Director 1 Yes 2X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera U.S.A. 12609 St. James Road 20850 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Armed Forces 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Furniture Sales Owner/Manufacturer it. Page 1 and 2 should be filed with thrent of Health and Mental Hygien trant: If Item 27 Is marked other 1 hiury or other traumatic event, the 8 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ρ Nabiha Miriam Ayoub Joseph George Saah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11613 Brandy Hall Lane, Gaithersburg, Maryland 20878 Christopher Saah - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department Important: It any Injury or 11/26/2012 Rockville, Maryland Parklawn Mem. Park 22. Narrie and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee Þ 0730 11800 New Hampshire Ave., Silver Spring, MD 20904 Denny Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
3 Days Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examine Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ending physician and ruse as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy
performed?

1 Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify, Certificate: To 1 ☐ Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred XX Natural (Month, Day, Year) 3 ₩ Fending s after deau.ral Director: Aftr work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral DI completely filled in Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Merria November 18, 2012 D25348 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15020 Shady Grove Road, #300, Rockville, Maryland 20850 Marcia Goldmark. M.D., 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. nt's Name,(First, Middle, Last, Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 221 Cresswell Road Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 03/24/1939 Min. Country) Georgia Director 1 □ M 2 🖒 F 213-36-4922 73 Yrs Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 221 Cresswell Road 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, <u>the Me</u>ury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) Did Not Work N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Lloyd Bryce Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Cresswell Road, Baltimore, MD 21225 Lloyd Earl Pryor /Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If its any injury or ot once, 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, Po Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ terminal Bonel obstruction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate causa. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) signed by the attending physician and defected for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No . Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier NSILW (4PAIN) 29c. License number 29d. Date signed (Month, Day, Year) 00057465 5203 Baltimore MD Z1209. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WSKYWWKSKIMP 183S SMIM AV wskyapaksemp

Registrar

31. Date filed (Month, Day, Year)

NOA 5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1605 Novembe Donna Rae Sparks 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Easton Talbot Temorial Easton ospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/24/1947 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🗆 M 2 🕮 F Director 218-50-0804 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examines must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? sparks, Donna Funeral 21655 **USA** 21182 Marsh Creek Road, Lot 29 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Š 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only high grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cleaning Service Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lula Mae Walter B. Cummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. Gregory Sparks / Husband 21182 Marsh Creek Road, Lot 29, Preston, MD 21655 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/28/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, Po Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Breact Metastatic Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Plevral Malignant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Þ Heart Disease icate has been siç r, page 2 should t 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 🗍 Unknown Completed ension 24b. Were autopsy findings available prior to completion of cause of death? er 24a. Was an performed? Yes 2 N To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 3 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06956 Mohan NOV, 25, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 2012 William Stansbury 12:00 AM Harrison Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ManorCare Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) 07/11/1951 **Funeral** 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Country) Maryland Director 1 X M 2 □ F 214-56-2567 61 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 341 Melvin Avenue, Apt. 21228 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. \$ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Unkn Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Stansbury, Sr Virginia Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any Injury or other trau once. Sadie M. Stansbury / Wife 341 Melvin Avenue, Apt. A, Catonsville, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/27/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician STAGE IVER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ٦ Sequentially list conditions, Examine if any leading to inmediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed attending physiclan and I for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Day is certificate has been signed by the a director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospitai Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS UM SPRINGS VICTORY NOV 2 9 2012 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ a^{M} Silvers 2012 6:00 Perry Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Upperco Hanover Pike If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) Director 242-52-9798 1X M 2 - F 78 Yrs Aug 5, 1934 NC Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shovary injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 Yes 2 X No Baltimore Upperco MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21155 15621 Hanover Pike 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. rmed Forces?

XYes 2 No Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lumber Logging Jack 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Rossie Carpenter Dallas Silvers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upperco, MD Hanover Pike Bonnie Silvers 15621 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/28/12 Upperco, MD Emory Cemetery 21. Signat of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart follows. List only one cause on each line. Reisterstown, MD 23a. Part 1. Enter the Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** 2015 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE f yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Month Year Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? certificate Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation filled in by the 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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completely fi P

31. Date filed (Month, Day, Year)
NOV 2 9 2012 State Registrar

29a. Certifier

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only one

29b. Signature and title of certifier

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Medical

Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 TASKER mo 32. Registrar's

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3831 Certificate of Death Reg. No. edent's Name (First, Middle, Last) 3. Time of Death 2355 2. Date of Death Month Physician/ MON Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Tate Hospice House . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number Months Days Hours Min. 06 128 1933 PA 79 179 26 8356 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State at with the Maryland Funeral Director Examiner must be notified 1 Yes 2 No Pasadena Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 **23**a 21122 U.S.A. 8423 Bay Rd items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ò 1 Never Married 2 Married ģ 1953 filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates White 3 Widowed 4 Divorced "natural" Completed 1976 the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Army Claims Investigator permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ellen Rosney Martin Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8423 Bay Rd Pasadena, MD Nancy Smith - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Veteran's Cem 12/03/12 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility GJ Gonce Funeral Home, 21122 Pasadena, MD 169 Drive Riviera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause and line. or respiratory arrest, Approximate Interval Between Immediate Cause (Final W830775 Physician/ disease or condition Medical resulting in death) Due to (or as 2 onsequence of Examiner Esqueritary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Pregnant at time of death Other (specify) been signed by the a should be detached 1 L Yes 2. 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has birector, page 2 s autopsy performed? death? 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospice မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending e Funeral Director: After death. 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Name and address of p

445 Registrar's Signature

EN

who completed cause of death (Item 23a)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ovember 28 Physician/ ar ason2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore City DKINS Hospital n/a 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 049-86-5502 **Director** 1 X M 2 □ F 33 Feb.2, 1979 Connecticut Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington n/a Washington D.C. 1 X Yes 2 No D.C. 10e. Street and Number 10g. Citizen of What Country? Funeral 1815 Riggs Place Apt.28 NW 20009 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 Is marked other than "natur traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Real Estate Sales Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stephen Tar Leslie Illman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Samp Mortar Drive Fairfield, Connecticut 06824 Stephen Tar/father 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot cemetery, crematory or other place)
Metro Crematory, Inc. 1 Burial 2 X Cremation 3 Removal from State 11/29/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signal of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner lyelodysplastic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlar-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Yes 2 □ No g 🔲 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2-No ၉ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 28, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 1800 Orleans St. Balfimore, MD 21287 dword 31. Date filed (Month, Day, Year) State NOV 2 9 201

Registrar

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 38315 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Burran Tarhan 4:20p M 2012 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care of the Chesapeake Arnold Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 129-32-6049 1 🗆 M 2 🛛 F 02/24/1926 Turkey permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, its Medical Examinar must be notified at 10a, State 10b, County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10201 Grosvenor Place, #1013 20852 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced White. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kemal Alp Munevver Kilic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9407 Fernwood Road, Bethesda, Maryland 20817 Leyla Ayse Kazaz - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Norbeck Memorial Park! 11/24/2012 Olney. Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee atri 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia Alzheimer's disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Completed by Physician/Medical Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No Month 5 Other (specify) Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Hypothyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hupertension performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🛴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0073574 November 20, 2012 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) M.D., 8601 Veterans Highway, Suite 204, Millersville, MD 21108 Natalah Karimova,

\^Q DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 29

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of	iviai ylai			e of Dea		Mental Hy	Reg. No.	2016	38318	
Physicia /Medic		1. Decedent's Name (First, Middle,	Last) David P	hillip Vi	gue				2. Date of Do Month	eath Day	- I mi	3. Time of Death	
Examin Funeral Director		4a. Facility Name (If not institution, 9 Frank III Sq. 5. Social Security Number 135-48-7953	ware H	05Pi	tal last birthday) Yrs.	Ro	Town, or Locat Sed 1 Year If Un Days Hou	R ender 24 Hrs.	8. Date of Bi	1	Co	h OCC hplace (State or Foreign unity) ew Jersey	
0		Usual Residence of Decedent		100.0	. T							10d. Inside City Limits	
vode i	ō	10a. State 10b. County		10c. City, Town or Location Baltimore								Yas 2 No	
r 28a-	rect	10e. Street and Number				10f. Zip		illore		10g. Cîti	izen of What Co	untry?	
23a o	ai Di	533 Fuselage Avenue					212	221			USA	A	
dical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	ent Everin (es? N No es:	1	Was Deced If Yes, spec			pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, White Specify:			
ical E	ted	15. Decedent's	Education		16a. Dece	dent's Usua	al Occupation	most of wor	rking	16b. Ki	ind of Business/		
be filed within 72 hours after ital Hygiene. Ind other then "natural", or Ite event, the Medical Examins	Completed	Elementary/Secondary (0-12)	Musician								Enterta	iinig	
4	To Be	17. Father's Name (First, Middle, La	st) Gerald Vigi	ıe			18. M	lother's Nan	ne <i>(First, Middle</i> Franc	e, <i>Maiden</i> ces Bal			
i if item 27 is marked of or other traumatic eve	_	19a. Informant's Name/Relationship (<i>Type, Print</i>) Mary Jane Vigue / Wife 19b. Mailing Address (<i>Street and Number or Rural Route</i> 533 Fuselage Avenue, Baltimore, M								ber, City o		Zip Code)	
permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trac		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from Si	ate	Place of Dispo cemetery, crei Chesapeal	osition (Nan matory or o	ne of ther place)	I	Date 8/2012		20c. Location - City or Town, State Beltsville, MD		
Importan any injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Durish Waryland Cremation Services, PO Box 1413 Ba											
attending physician and for use as the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	b. Pue lo (o	r as a conse	quence of):	den	st ninal	Asct	-ic An	کلات	y5m	Onset and Death	
sched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1								23d. Date of del Month	ivery Day Year	
s been signed by the a should be detached	d by Pł	Part II. Other significant condition	s contributing to dea	th but not re	sulting in the u	inderlying c	ause given in P	art I.		tobacco u		the cause of death?	
ate has page 2	Completed										death?	Itopsy findings available completion of cause of 2 No	
is certificate director, pag) Be	25. Was case referred to medical examiner? 1 No 2 No	Hospital:	patient 2	ER/Outpatier	aC DC			ath (Check only		6 □Other (Spe	-: 6.1	
fter th	tion: To	27. Manner of Death 1 Matural 5 Pending 2 Accident investiga	28a. Date of (Month		28b. Time o Injury		28c. Injury at Work? 1 ☐ Yes		28d. Describe			city)	
neral Director: A filled in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of building	f Injury - At t g, etc. (Spec	nome, farm, str ify)	reet, factory	y, office			(Street an own, State		ural Route Number,	
To the Funeral Completely filled	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the bas aminer: On the bas and manne	is of examin	iowledge, deat ation and/or in	th occurred evestigation	at the time, dat , in my opinion,	e and place death occu	a, and due to the urred at the time	e cause(s)	and manner as d place, and due	stated. to the cause(s)	
To tl	Me	29b. Signature and title of certifier	infl			290	. License numi	ber		29d. Da	te signed (Mont	h, Day, Year)	
		11/10/	101			1					_	2012 MD 2123	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** 10:30 AM Williams NOV 27 2013 Theresa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore** Johns Hopkins Bayview Medical Center Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** 1 🗆 M 2 🗗 63 Yrs MD 08/10/1949 214-50-2351 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c, City, Town or Location 10a. State 10h County at N/A 1 Yes 2 No MD Baltimore Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number traumatic event, the Medical Examiner must be 22nd Street 21218 301 E. U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) John Hopkins Oncology Tech. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daisy L. Scott Odell Lloyd Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4404 Plainfield Ave. Apt.5 Balto. MD 21206 Robert E. Huff Jr. (Son) Health a Item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any Injury or oth On-Site Crematory | | 29/12 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD ²² Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 21. Signature of Funeral Service Licenses illiamo 2140 N. Fulton Ave. Balto., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final failure Hupercurbic Due to for as a consequence of): **Physician** RESpiratery disease or condition resulting in death) /Medical **Examiner** Hupovenhahon Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events use as the burial-transit Due to (or as a consequence of: resulting in death) Last Box 68760¢ attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 NO been signed by the a 9 I Linknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate has 2 410 1 ☐ Yes 2 100 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 [No 2 ER/Outpatient 3 DOA 1 🗌 Yes မ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: il or Attending P s after death. I Director: After t 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide City or Town, State) 1 Actifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors.

Q

Medical

SWATH-ELURI 31. Date filed (Mon State Registrar

29b. Signature and title of certifier

(check only



and manner stated.

MD

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

11/27/17

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1023349503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Woodside 10:22 PM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A <u>3838 Roland Avenue, Apt.</u> <u>Baltimore City</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 72 **Director** 218-36-7794 1 □ M 2 🕅 F Apr. 3, 1940 Maryland Usual Residence of Decedent i Hygiene. ! other than "naturel", or Items 23a or 28a-f show vent, the Medical Everniner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Baltimore City N/A Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 21211 United States 3838 Roland Avenue, Apt. 711 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Importent: If item 27 is marked oth
eny linjury or other traumatic even
ones. ၉ Vivian Baker Ruby Elvy L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3838 Roland Ave., Apt. 711, Baltimore, Maryland 21211 Robert Woodside / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State 11/28/2012 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificete be executed thin 24 hours after death. l by the attending physician and stached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Xes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) ᅙ 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗆 No М Investigation 3 ☐ Suicide 4 ☐ Hornicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28 Ш

5

State Registrar Betsy A. Fay, 37 31. Date filed (Month, Day, Year) NOV 2 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State o	of Marylar		irtment of F <i>tificate of D</i>	Health and N Death		giene Reg. No.2 (112	38319			
Div	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Ye										Year	3. Time of Death			
	∕sıcıaı ⁄ledic	al L	Floyd Woodson 11 18 20									2:15 A ^M			
Exa	amine	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Glenarden Prince									orge's			
Fun	eral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign			
Dire			227-56-8819	1 [X M 2 □ F	6	7 Yrs.	Months Days	Hours Min.	(Month, Day April 2	20.1945	Virg	nia			
but show	at	. h	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loc	ation		<u></u>		11	Od. Inside City Limits			
Maryla 28a-f	tified	Director	MD Prince	e George'	s Gle	narden						1 X Yes 2 □ No			
h the	pe no		10e. Street and Number				10f. Zip Code	_		10g. Citizen o	of What Coun	try?			
ath wit	must	Funeral	8640 Leslie Ave		edent Ever in U.	S 13 V	20785	ispanic Origin? (Spe	cify Yes or No-	USA 14 B	ace - Americ	an Indian			
Baltimore, IMaryland 21213-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Examiner	2	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	orces? 2 No /e	l1	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	В	lack, White, e	tc.			
Z1Z15-UU36 within 72 hours after giene. er than "natural", o	dical	Completed		it's Education st grade completed)	16a. Deced	ent's Usual Occupa	ation during most of worki	ina	16b. Kind of	Business Inc	lustry			
Ithin 7 ene.	he Me	E C	Elementary/Seconday (0-12)	College (1	,		NOT use retired)	hnician		Dri	vate				
Iled w other	vent, t	8	17. Father's Name (First, Middle, L			warei	louse rec	18. Mother's Name	e (First, Middle,						
ylar Id be f Menta Iarked	atic e	입	Wilson Woodson	n				Mary	Harris						
Viar	traum		19a. Informant's Name/Relationsh			1		and Number or Rura				rode)			
re, I and 2 Healt Tem 2	other	-	Vivian E. Wood	ison/Wire	20b.	Place of Dispo	sition (Name of	venue, G	Lenarder Date		. <u>0 / 8 5</u> n - City or To	wn, State			
Page 1	iry or		1 😾 Burial 2 🗌 Cremation 4 🗋 Donation 5 🔲 Other (S		Clate		natory or other plac ans Cemet	ery 11-26	6-2012	Amelia	a, Vir	ginia			
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth	any inju	_	21. Somature of Funeral Service L	milh d	wih		. Name and Addres		3. Jenki	ins Fur	eral E	Home, Inc.			
		7	23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that	caused the dea	th. Do not ente	r the mode of dying	g, such as cardiac o	or respiratory arr	rest,		Approximate Interval Between			
	Physician/ Immediate Cause (Final disease or condition Cardiac Arrest											Onset and Death			
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certificate be	as the	e i		d			-								
ords, P.O. BOX 68/ v requires that the death certific been signed by the attending is	ned for use	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	as decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of Pregnant 2 Fetal death 3 Compared to Pregnancy 4 Pregnant at time of death 5 Other (specify) Month							Date of delive Month	ery Day Year			
that the	detac	Ž.	Part II. Other significant condition	ns contributing to c	death but not re	esulting in the u	nderlying cause giv	ven in Part I.				e cause of death?			
dS, quires	d blue	ted							1 🗆 '	Yes 2 No	3 Prob	pably 4 🕅 Unknown			
DIVISION OF VITAI RECORDS, P.O. BOX To the Hospital or Attending Physician: The law requires that the deathwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte	page 2 sh	Completed							24a. Was a autop perfo 1 Yes	rmed?		osy findings available inpletion of cause of			
Ital ician: certific	ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	ace of Death <i>(Checi</i> er:							
OT V	eral dii	e:	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a, Date	Inpatient 2	28b. Time of	28c. Injun	4 □ Nursing Ho y at	ome 5 X Resid 28d. Describe h						
On C anding sath. or: Afte	he fun	ficat	1 Natural 5 Pendin 2 Accident Investig	gation	nth, Day, Year)	injury	M 1 🗆	? Yes 2 ☐ No							
or Atta	in by t	Certificate:	3 Suicide 6 Could 4 Homicide determ	inod 28e. Place	e of Injury - At h ing, etc. <i>(Specii</i>		eet, factory, office		28f. Location (S City or Tow		nber or Rural	Route Number,			
ospital hours uneral	pa tilled	Medical		Physician: To the b								d. ise(s) and manner stated.			
the H thin 24 the Fu	трете		only one) 3 Certifying	Nurse Practioner:			leath occurred at the	e time, date and place	e, and due to the	e cause(s) and	manner as sta	ated.			
o ^{kit} o	8		29b. Signature and title of certifier	Palas			29c. License	76 9		29d. Date sig) 6 / J	эау, теап			
	,		30. Name and address of person	who completed cau	se of death (Iter	m 23a) (Type, F		` (- 1()	- 110				
<u>り</u>			Rakesh Sahn		474 Gre	enway (Center Dr	ive, Gree	enbelt,	MD					
Re	Stat gistra	_	31. Date filed (Month, Day, Year) NOV 2 9	2012	legistrar's Signa	A. A.	ales								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:15 A Medical Name (if not institution. give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Loc timore 9. Birthplace (State or Foreign Country) Social Security Number last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** 1 M 2 XF Min. Months Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2/2/8 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No If Yes, Give Year or Dates Specify Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry tary/Seconday (0-12) (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) . Page 1 and 2 should be filed within 72 iment of Health and Mental Hygiene. tant: If item 27 is marked other than ' College (1-4 or 5+) Various abore Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yar Kway nerman 20b. Place of Disposition (Name of cemeter), crematory or other 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fundial Service Licensee March F/H-East 110 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Annroximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Lexia Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme 2 No 2. N Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Matural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner To the best of my knowledge 29b. Signature and title of certifier 29c. License number ompleted cause of death (Item 23a) (Type, Print) Name and address of per

Registrar DHMH 17 Rev 7/2009

State

6091

on who

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Wright November PM 24. Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Phins Datim Hospita re 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours **Director** 1 X M 2 □ F 28a-f show 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at **Funeral Director** 10d. Inside City Limits altin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 1 Yes 2 No If Yes, Give Black, White, etc. ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No "naturei" Black 3 Widowed 4 Divorced Specify: Year or Dates treumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only high Should be filed within 72 h end Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Norke truction Be 17. Father's Name (First, Middle, Last) Un Known 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a Department of H Importent: If ite eny injury or ot 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Baltimore 3/2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee March F/H-East 3 months Miller Ave. Ba 1101 Himore, MD 21202 North Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ obstructure disease or condition Dulmonan Chronic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam the buriel-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗌 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

• Funeral Director: After pletely filled in by the fur Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one) 29b. Signature and title of certifie 29c. License number m. 2 November 24, 2012 MD INDH RES-DOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1900 Orteans Street. Baltimore MD. Michael Ehmann, MD MPH

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2012

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Howard F. Wiedey, Jr. 2012 10:20 AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner 4003 Green Glade Road Phoenix 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours TXXM 2 D F Balt., Maryland 66 Director 217-46-0350 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Phoenix Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code Ь 10g Citizen of What Country? United States or than "natural", or items 23a or the Medical Examiner must be 21131 Funeral 4003 Green Glade Road of America death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of fleath and Mental Hygene. Important: If item 27 is marked other any injury or other trans Armed Forces?

**TXX*Yes 2 \sum No If Yes, Give Year or Dates. Black, White, etc. δ 1 Never Married Married white 1 ☐ Yes 2 No Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Owner 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard F. Wiedey, Sr. ᅌ Elaine Danz 19a. Informant's Name/Relationship (Type, Print)
Mrs. Christa M. Wiedey/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4003 Green Glade Road Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Thursday Evans Funeral Chapel- Bel Air 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland Nov.29,2012 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Runeral Service Licenses Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) an YEAR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Attending Physician: The law requires that the death in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No this certificate 2 🗌 No 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? M 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 0 Hospital To the Funeral Medical

State Registrar 29a. Certifier (Check only one)

9

of person who completed cause of death (Item 23a) (Type, Print) 670

32. Registra

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 28 11

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ NOVEMBER 15.10 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give 4c. County of Death Examiner ehab timore 0a/ If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 №M 2 🗆 F 4-1, 2ay, 19140 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Funeral items 23a 21286 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ō δ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NO yuse retiged) 16b. Kind of Business Industry ध Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number MU 21286 0W500, reddie Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State or other place. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee eene Funeral Services -MO1665 21212 hs that caused the death. Do not enter the mode of dying, such as cardiac or se on each line. 23a. Part 1. Emer the disease, or con Approximate Interval Between shock, or heart failure, List only o Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to or as a conse uence of: MELLITUS MIABETES executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical KIDNEY DIS CABE CHRONIC or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown page 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 Yes 2 No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 068394 2012 MP NOVEMBER LEVINDALE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. BELVEDERE AVENUCE BALTIMORE 21215

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Neil Drew Wilkin. Sr. November 27. 11:00 am 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20030 New Hampshire Avenue Montgomery Brinklow Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours (Month, Day, Year) **Director** 380-36-4287 1 X M 2 □ F 75 July 18,1937 Michigan 23a or 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maruland Montgomery Brinklow 10f. Zip Code 10g. Citizen of What Country? Funeral 20030 New Hampshire Avenue U.S.A. 20862 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: 3 Divorced 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Electrical Engineer US Government permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis Wilkin Dorothy Drew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20030 New Hampshire Avenue, Brinklow, Maryland 20862 Nancy Jean Wilkin - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 12/01/2012 Burtonsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Warner 232 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreas Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🛛 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D19294 November 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 911 Russell Avenue, John Melnick. Gaithersburg, Maryland 20879

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

NOV 29

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death M911/1/2012 326 M Physician/ TALISHA C. ADAMS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) . Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213-78-9570 Director 1 □ M 2 🔀 F 41 8/31/1971 WASHDC Usual Residence of Decedent er then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location flled within 72 hours efter death with the Maryland Directo 1 X Yes 2 No Montgomery Takoma Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1510 Paula Drive 20903 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 X Never Married 2 ☐ Married ۾ altimore, Maryland 21215-0036 1 Yes 2 No Black If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retireof the Ark of Montgomery Cty 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Non-Profit 12th Contractor ith end Mental Hygie 27 is marked other r treumetic event, Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pege 1 end 2 should be file Depertment of Heeith end Mental I Importent: If item 27 is marked o eny Injury or other treumetic eve 90x8. Earl R. Adams Yvonne Viola Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1510 Paula Drive, Silver Spring, MD 20903 Yvonne Viola Adams /mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation Ctr of MD 11/5/2012 Hanover, Md 21. Sign sture of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Condecrascular disease ₽nysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospitel or Attending Physician: The lew requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien end Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 No Yes Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 XN 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 0 6 2012

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Kan D.0.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kapro, 7600 Carroll Avenue, Takoma Park, MD 20982 . Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 6. Physician/ 2012 Camila Lontoc Anniversario November р м 5:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Min (Month, Day, Year) None Director 1 □ M 2 🗗 F 66 Nov. 26, 1945 Philippines Usual Residence of Decedent mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bartnent of Health and Mental Hygiene.

Journant: If item 27 is marked other than "natural", or items 23a or 28a-f show ordant: If item 27 is marked other than "natural", or items be notified at injury or other thaumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ph**ili**pp**i**nes Batangas 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 San Jose Street, Taal 4208 Philippines 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 K No Specify: Specify Pacific Islander 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Bank Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Lualhati Ramon Lontoc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annalee A. Elias/Daughter 3946 58th Street, Woodside, NY 11377 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 🖾 Removal from State Nov 2012, permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Holy Land Memorial Park Batangas, Philippines 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysiciani Atheroscleratic Coronary Vascular Dise a. Hypertensive disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): e attending physician and ed for use as the burial-tansit Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year been signed by the a should be detached 1 ☐ Yes 2*☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Non Insulin Dependent Diabetie 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate funeral director, pag ☐ Yes_ 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide within 24 hours after dealh
To the Funeral Director. A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signata e and title of certifier D0064502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Rockville MD 20850 Brian der ho medical Par Dr 31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 06-2011

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38327 20B & 20C Per Gartificate of Death RegistrarAmend Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anthony Month Oct 30ay2012 Year George 06:05Am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Medical Center Prince Georges Fort Washington Social Security Number **Funeral** 7. Age (In yrs. last birthday) f Under 1 Year | If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 425-38-7957 4/22/1927 Year) Director 85 1 XXM 2 - F Tennesce Usual Residence of Decedent Tennessee or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Oxon Hill Prince George 1 Tyes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral U.S.A. 20745 2164 Alice Ave <u> Apt # 104</u> "natural", or items and 2 should be filed within 72 hours after death wealth and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1★★ Yes 2 □ NoArmy If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dept Of Public Works D.C.Govt 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Andrew Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Anthony (Brother) 3400 Commodore Joshua Barney Dr Washington DC 20018 20b. Place of Disposition (Name of MD, caretex compatory of other place)
W. Tonnosce Vet Cametery Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of 1 xxBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memphis Tenn Nov 16,2012 heltenham, 21. Signature f Funeral Servi 22. Name and Address of Facility Roger J Mason Funeral Service 908 Kennedy St NW Wash DC 20011 he ... or complications that caused the death. Do not enter the mode of dying, sur lure. List only one caus. on each line. shock or heart Immediate ause disease or condition Interval Betwee set and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Secure finity list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
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1 \(\subseteq \text{Yes} \) pletely filled in by the Accident Investigation 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29d. Date s 30 2012 10 25's 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.M. Ahleham 11711 Livingston Rd Fort Washington Md 20744 Registrar's Signat State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Beddow Armstrong 2012 6:50 a.m. November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary' Hospice House of St. Mary's Callaway S If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Days 140-56-4351 Director 1 □ M 2 🛛 F 54 11/07/1958 Virginia ?? is merked other then "nature!", or items 23e or 28e-f shov treumetic event, the Medical Examiner caust to myilled at 10b County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2X No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pege 1 and 2 should be filed within 72 hours efter death with nent of Health and Mental Hygiene. ent: If item 27 is merked other then "naturel", or items 23e 20653 United States 47850 Snow Hill Way 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) end Mental Hygiene. is merked other the Financial Officer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Doris Hitchins Thomas Franklin Beddow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 888, Lexington Park, MD William T. Armstrong/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 11/14/2012 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signeture of funeral Service Sciensee

Michele Brinsfield N01652 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Due to (or as a consumence of): Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ettending physician and for use es the burlei-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant : Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, pege 2: the Hospital or Attending Physicien: 'thin 24 hours efter death, 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence (Nother (Specify) 27. Manner of Death

1 ► Natural
2 □ Accident 28a. Date of injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Suicide within 24 hours efter dea To the Funerei Director completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my activity. Medical 29a. Certifier * Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier JOV 30. Name and address of peg completed cause of death (Item 23a) (Type, Print)

State Registrar Jennifer

31. Date filed (Month, Day, Year)

Schmidt,

D.0

40900 Merchants Lane, Suite 205, Leonardtown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ NOV. 19 2 0 T 2 11:45AM MARGARET LILLIAN ALSCHER Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CHARLES 4183 LOG TEAL DRIVE WALDORF 8. Date of Birth Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min NOV.21,1923 ILLINOIS Director 577-20-8282 1 🗆 M 2🗴 F 88 show 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director r 28a-f sh notified MD CHARLES WALDORF 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ms 23a or must be r Funeral 20603 U.S. 4183 LOG TEAL DRIVE items within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iter edical Examiner Black, White, etc. 1 Never Married 2 Married þ 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3¥2¥Widowed 4 ☐ Divorced Completed Year or Dates WHITE er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) LOAN OFFICER BANKING t of Health and Mental Hygie If item 27 is marked other or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 1 and 2 should be f Health and Menta ADELE MILBRANDT SIGMUND R. MILBRANDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18414 RIM ROCK CR., LEESBURG, VA 20176 ADELE R. ELEY/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or once, 11/28/2012 CHELTENHAM, MD MD VETS.CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Signature of Funeral Service 20646 M00641 5635 WASHINGTON AVE., LA PLATA, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him eviate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death detached Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by or Attending Physician: The law requires 1 Yes 2 No 3 Probably Completed Should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes has 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No +☐ Natural 5 Pending er death rector; / Accident Investigation in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 24 hours a Funeral I Medical 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2
To the comple only one) 29b. Signature and title of certifier

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Date filed (Month, Day, NOV 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day PHYLLIS J. ANDERSON Physician/ 2012 4:00 Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 1546 Arena Road Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 3/29/1942 Days Hours 233-64-1895 70 **Director** 1 □ M 2 🛛 F WV Usual Residence of Decedent show 10a. State 10d. Inside City Limits must be notified at 10b. County 10c. City. Town or Location Director Harford Street MD 28a-f 1 Yes XXNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 23a 21154 USA 1546 Arena Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 ₩ Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home the Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental His marked o မ Irene Mary Walton Elmer David Brock traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1546 Arena Road, Street, MD 21154 Department of Health an Important; If item 27 is any injury or other traconce. 1546 Arena Road, Street, MD Melissa G. DeBoard/Daugh. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Dublin So.Cem. 11/14/12 Darlington, MD Donation 5 Other (Specify) 21. Signature of June al Service Lic 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cardiomyopath Medical resulting in death) **Examiner** disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exam Hypertension the burial-trar and resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 P. Anderson IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESRO, peripheral artery 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown valvular heart disease 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate has Pulmonary hyper tension 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ filled in by the funeral Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 5 Pending after death. 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November. 12,2012 pleted cause of death (Item 23a) (Type, Print) Bel Air, MD Chesapeake per 20

DHMH 17 Rev 06-2011

State

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8411 Quintana Street New Carrollton P.G. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 217-42-0459 **Director** 69 1 AM 2 F July 3, 1943 Washington, DC 28e-f show 2 should be filed within 72 hours after death with the Maryland with and Mental Hygiene.

27 Is marked other then "natural", or items 23e or 28e-f short treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director P.G. MD New Carrollton 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8411 Quintana Street 20784 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 Specify:White 1 ☐ Yes 2 Ø No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) IT <u>Manager</u> Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Angelo Bello Carmela Longo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is eny Injury or other treu once. Rose Mary Bello/Wife 8411 Quintana Street, NEW CARROLLTON, MD 20784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖺 Burial 2 🗌 Cremation 3 🔲 Removal from State Nov. 2012 Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ KNCER LUNG disease or condition resulting in death) car Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 5 Other (specify) 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Yes 2 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 🛭 Residence 6 🗆 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

NOV 06

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 SOMPHONE BOUTJAREUN NOV 5:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 578-04-6636 1 🗓 M 2 🗆 F 52 LAOS APRIL 1,1960 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other then "neturel", or items 23a or 28a-f sho erry injuy or other traumatic event, the Marital Estation man be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? Funeral 1505 HAMPSHIRE WEST CT. 20903 LAOS 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XNever Married 2 Married ğ 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed ASIAN Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 LABORER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ BOUNPHONE KHOUNAMACHACK BOUNPHENG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRIEND CHRISTIAN P. BOUNSYNHAVONG 505 HAMPSHIRE WEST CT. #6, SILVER SPRING, MD.20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Dunal 2 X Cremation 3 D Removal from State 4 Donation 5 Other (Specify) 11-10-2012 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Eaching HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HIGH GRADE LYMPHOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed FAILURE TO THRIVE resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 use es 1 ettending properties IF FEMALE. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🔯 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After completely filled in by the function of the funct 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who

KSHAMA

07

31. Date filed (Month, Day, Year)

GARG

M.D.

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D60826

1500 FOREST GLEN RD., SILVER SPRING, MD.

NOV. 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:12 PM SUE THUME BRITTINGHAM october 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur Salisbury Reha bilitation + Nursing omico If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min. Country) 217-28-2710 81 Director 1 🗆 M 2 🏝 F OCT. 27, 1931 MARYLAND or 28a-f shov 10a, State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notifled at death with the Maryland Director WICOMICO SALISBURY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera USA 21804 316 CALVIN DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: WHITE Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) C&P TELEPHONE ADMINISTRATIVE ASSISTANT other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ CHARLES MELVIN THUME MARGARET GREENWOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 CALVIN DRIVE, SALISBURY, MD ALAN BRITTINGHAM, HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/7/2012 OXFORD CEMETERY OXFORD, MARYLAND 4 Donation 5 Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 SOUTH HARRISON STREET, EASTON, MD 21. Signature of Funeral Service Licenses 21601 JOHN R. m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rease Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) If any, leading to infriedlate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical T. Brittingham of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 🗆 No 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe Yes 2 death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Shursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division death, 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) after Hospital or n 24 hours Medical 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 311 10 s of person who completed cause of death (Item 23a) (Type, Print) DSID 110 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ILONA BOGNAR 0630 AM 6 201 NON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY MONTGOMERY VILLAGE 9424 WHETSTONE DRIVE 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) 217-33-5798 Director 80 1 M 2 M F 03/27/1932 HUNGARY Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or itams 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY VILLAGE MONTGOMERY MD 1 N Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20886 9424 WHETSTONE DRIVE USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hyglena. Elementary/Secondary (0-12) College (1-4 or 5+) BUSINESS OWNER CLEANING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be filed nt of Haalth end Mantal H t: if item 27 Is markad ot or other traumatic ever ည ILONA BELAK FERENCE TOTH 19a. Informant's Name/Relationship (Type, Print) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 9424 WHETSTONE DR., MONTGOMERY VILLAGE, M 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDITH KARPATHY / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MONOCACY CEMETERY 11/10/2012 ò permit. Page Dapartmant of Important: if any injury or once. BEALLSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Inset and Death B SC Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attanding physician and I for use as tha burlal-transit Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate ba Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day signed by the at Id be datached for 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has baan sig ; paga 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this cartificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No To the Hospital or Attending Physician: I within 24 hours after death.
To the Funeral Director: After this cartifics complatally filled in by the funaral director, I 8 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one ignature and title of certifie d Mas 10 mg NOU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Rigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 27. Sharon Lee Brewbaker 4:05 p M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Lorien Nursing & Rehabilitation Ctr Taneytown Social Security Number 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday If Under 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 218-46-4875 Director 1 🗆 M 2 😿 F 65 Pennsylvania Nov 23, 1946 Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 USA 412 E Baltimore St 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black White etc 1 Never Married 2 Married Completed by 1 Yes 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Book Publisher Office Worker 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fif Health and Mental ൧ Lavina Mahanna unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Eckenrode, brother 14 New Windsor Road, Westminster, MD 21157 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemeter Scouting or other place) 10/30/2012 4 Donation 5 Other (Specify) Carroll Crematory Winfield, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral 136 E Baltimore St, Taneytown, MD 21787 Part D Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 🔀 No Year Month Day 1 ☐ Yes 2 ¥ Unknown þ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be de þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform Yes 2X N 1 Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Sulciue 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier H0061206 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Tracie Ry ber 880 Poole Wistminster MD Road

State Registrar

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edith Unkle 2012 :15 p.m. Bean November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 49697 Bayne Road Ridge St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours (Month, Day, Year) Director 219-48-5240 1 □ M 2 🗓 F 95 05/27/1917 Maryland Usual Residence of Deced 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💆 No Maryland St. Mary's Ridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 49697 Bayne Road 20680 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No 3 X Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highe est grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sarah Combs <u>Joseph Frederick Unkle</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49697 Bayne Road, Ridge, MD 20680 Frances Bean Titus/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1.
Department of Important: if it any injury or of once. ₽ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/13/2012 Lexington Park, MD James Cath. Cem. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death CVA Immediate Cause (Final CENTERRUN SCULAR SOCIEDANT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and buriai-transit Exam or Attending Physician: The law requires that the death certificate be executed DEMIGNITIA Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a compietely filled in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the pasis of examination arrows investigation, in my opinion, actual occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R082231 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(2) KMV State Registrar

41680

32. Fegistrar's Signature

Tarleton.

Marie

Miss Bessie Drive, suite 301, Leonardtown, MD 20650

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral		10 00 .		e (In yrs. la	ast birthday)	If Under	1 Year		24 Hrs.	8. Date of B	irth	nne .	g. Birth	place (State or For	eign
Director		Usual Residence of Decedent	1 X M 2 □ F	6	4 Yrs.	Months	Days	Hours	Min.	Oct 2	29 1	.948	Mar	yland	
the Maryland or 28a-f show e notified at	Director	10a. State 10b. County Maryland Baltin	more		y, Town or Lo									10d. Inside City Lir 1 ☐ Yes 2 🎇	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 4935 Brookwood	d Rd.	I		10f. Zip (Code 122	5			10g. C	itizen of Wh	at Cou	ntry?	
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To the Hospital or Attending Physician : The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.	Completed by Physician/Medic	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	☐ Ectopic pr ☐ Other (spe		у				23d. Date Month		Day Year	
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To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	al Ce		building, etc							City or To	wn, State	e)			
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ BASS 11 9:15 PM the Mae Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL CENTER ANNAPOLIS, MD ANNEARUNDEL MEDICAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, **Funeral** Days Hours Maryland 220-60-8882 Director 1 □ M 2X F Dec 1951 60 ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 Yes 2X No Anne Arundel Annapolis Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 804 C Brooke Ct. 21401 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 7. Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 9th Custodian Cleaning Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Elmore Roberts Mildred Stansbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,21061$ Vanessa Cain(Daughter) 414 Hiddenbrook Dr. Apt I Glen Burnie, Md. item 2 20a. Method of Disposition 20b. Filace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 11-12-12 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Miniame Record & Cili Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 4DVANCE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law required with a within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for I in the past 12 months? 4 Pregnant at time of death Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☑ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEUMONIA 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN 11-03-2012 A005102

State Registrar 2001 MEDICAL PKWY ANNAPOLIS, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. KOMES M.D.

NOV 07

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month | Physician/ -orald Booth 3 2012 7:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Anne Arundel Medical Center Anne Arunde1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours (Month, Day, Year) 214-52-9340 Director 1 M 2 D F 64 une 10 1948 Maryland filed within 72 hours are...ed Hygiene. tal Hygiene. ed other than "natural", or items 23a or 28e-f show ed other than "natural", or items 23a or 28e-f show est other than "natural" or items 25a or 28e-f show ed other than "natural". 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 314 Chester Ave 21403 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give 1967-71
Year or Dates. Black, White, etc. 1 Never Married 2X Married ≦ Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) 12th College (1-4 or 5+) Plumber Naval Academy Be 17. Father's Name (First, Middle, Last) ige 1 end 2 should be filed nt of Health and Mental H t: If item 27 Is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Booth Daisy Blunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah J. Booth(Wife) 314 Chester Ave Annapolis, Md. 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Importent: If i 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veteran 11-13-12 Crownsville, 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses MINAME REMEMBER & Mortuary, 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cancer Physician/ disease or condition resulting in death) 1050 Medical Due to (or as a consequence of) [']Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day certificate has been signed by the a irector, page 2 should be detached i 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Avenber 3, 2012 No 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 Medical Suite an Amapolis MO Tweed MD Karkenay

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Registrar's Signatur

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Funeral		5. Social Security N	umber	6. Sex		yrs. last birth	day)	If Under 1 \	Year Days	If Under	24 Hrs. Min.	8. Date of Bi		g.	Birthpl: Countr	ace (State or Fo	oreign
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Page 1 and ment of Her ant: If item ury or othe		20a. Method of Disp 1 Derial 2 4 Donation	cemeter						2, 2012	•	on - City or Town, State erick, Maryland						
permit. Departr Importa any injt		21. Signature of 5d	Name and A sthave	of Facility uner in M	ervice ain Hw	ervices, Skko in Hwy. Fred			P.A. MD_217	701							
Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myelodysplastic Syndrome Due to (or as a consequence of):														Approximate Interval Betwee Onset and Dea Ironic	
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ath certifi ttending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 gnant at tim	Fetal death		Ectopic preci				23d. Dat				y Day Yea	ır
requires that the des been signed by the a should be detached	by	Part II. Other signif	ficant condition	ons contributing to d	death but n	ot resulting in	the u	nderlying cau	ise give	n in Part I	l.			use contribute			
sician: The law req certificate has bee lirector, page 2 sho	Completed											24a. Was auto perf 1 \(\sum \) Yes	psy ormed?	prior death	to com	sy findings ava apletion of caus	
ysician: iis certifica director,	Be	25. Was case referrexaminer?		Hospital:					26. Plac		-	only one)					
ding Phys th. After this funeral di	cate: To	27. Manner of Deat 1 X Natural 2 □ Accident		28a. Date (Mor		2 ER/Out 28b. Ti ear) in			Injury a work?	4 ∐ Nu	2	me 5 XRes 28d. Describe		6 Other (S)	pecify)		
al or Attending s after death. I Director. After d in by the fune	Certificate:																
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of certifying they so Practitionery To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying They so Practitionery To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											er stated.				
To the within To the Comp.	۷ .	29b. Signature and						29c. Li	672	number			29d. D	oate signed (Moember 2	onth, D	ay, Year)	
5		30. Name and addr Nicholas	ress of person S J. Fa	who completed caurrell, M.	se of death D. 9	1 (Item 23a) (T 1 7 0 7 M€	ype, P	rint) cal Ce	ntei	r Dr.	, St	e. 300	, R	ockvill	e,	MD 208.	50

State Registrar 31. Date filed (Month, Day, Year) 5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov. 6, 2012 1705 Thelma Bernice Battle p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Hospital Center Prince George's Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 577-44-8697 1 □ M 2 🏻 F 79 Usual Residence of Decedent <u>April</u> 17, Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 X Yes 2 No Seat Pleasant 10f. Zip Code 10g. Citizen of What Country? Funeral 414 Milfan Drive 20743 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates African American 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy rigury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Henry Spriggs Annie Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) Timothy Lavon Hawkins - Grandson 14203 Woolen Oak Court # 2 Silver Spring, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. Date 9. 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Olivet Cemetery 2012 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road NE Washington, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exam the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit resulting in death) Last physician by Physician/Medical Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 wonths? 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death Other (specify) Dav Year 1 | Yes : a Hinknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has the funeral director, page 2 perform 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 🕽 Other: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Date of injury (Month, Day, Year) 27. Manyer of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the formal properties. Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) 5_{JM} 30. Name and address who completed cause of death (Item 23a) (Type, Print) State 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Marvand 2626 at the health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov. 1 1 ay Physician/ COLLEEN ALEXIS BLAKEMAN 2012 8:32A M Medical 4b. City, Town, or Location of Death Havre de Grace 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford **Examiner** Harford Memorial Hospital S226 ecurity Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 227-49-9764 15 Director 1 🗆 M 2 🔀 F 8/11/1997 MD or 28a-f shov 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County 10c. City, Town or Location Director MD Harford Pylesville 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 411 Pylesville Road 21132 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. ģ 1 X Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Education 10 Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Natalie D. Colaric Kirk J. Blakeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Pylesville Road, Pylesville, MD 21132 19a. Informant's Name/Relationship (Type, Print) Natalie D. Blakeman/Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2X Cremation 3 Removal from State Evans Eagle Cre. 11/13/12 Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun Al Servige Licen 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ← Phylician/ disease or condition resulting in death) weenic Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Seizures physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Month Day 1 Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P. δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 certificate ! 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d, Date signed (Month, Day, Year) marca MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 604 Hoagle Drive Bel AN MD 21014 Lomanico 32. Registras Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Sarah Ann Barr 3:17 \mathbf{P}^{M} November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3999 Sugar Loaf Court Monrovia Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min 236-42-0058 96 **Director** West Virginia January 28, 1916 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be with 1 Funeral 3999 Sugarloaf Court 21770 United States of America 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than Elementary/Seconday (0-12) and Mental Hygiene. College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isaac Edward Rummer Margaret Virginia Crites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Paulette Triplett / Daughter 3999 Sugarloaf Court, Monrovia, Marylnad 21770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1 Department of I Important: If it November 21. 1 Burial 2 Cremation 3 Removal from State Riggleman - Barr - Hinkle injury or Rig, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cemetery Reeney & Bastord P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Pulmonary Fibrosis Sequentially list conditions, if any, leading to immediate cases. Enter characteristics Examine Due to (or as a consequence of). Congestive Heart Failure Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Pulmonary Hypertension 24a Was an page 2 s autopsy certificate 2 No 2**X** N 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Yes ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of Certificate: 28c. Injury at After X Natural 5 Pending work after death. 1 Yes 2 No Accident Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L

completed

within 2.

State Registrar

Medical

29a, Certifier

29b. Signature

(Check

only or

nd title of certifi-

Charles Karesh, M.D.

26033 Ridge Road, Damascus, Maryland 20872 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#8 per FH, 11/6/12; BWW. McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November Physician/ Cheng-min Chang aka Chengmin Chang 2012 12:36 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockv111e Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 233-90-5520 Director 1 🖾 M 2 🗆 F Yrs 1940 16 Taiwan Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Ves 2 X No Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9801 Betteker Lane 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Completed by Specify Asian If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government 6 Research Biologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9801 Betteker Lane, Potomac, MD 20854 Audrey S. Chang/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) Nov 2012, Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiovascular disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Be Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ed by the attending physician and detached for use as the burial transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day g Unknown g Unknown is certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 N this certificate 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 2 No ၉ 1 Yes 1 Inpatient 2 XER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this d in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fune 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 64068 MO

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

9901

32. Registrar's Signature

Medical Center Drive Rockville

MO 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Kalaria

NOV 0 6 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Betty F. Campbell 2012 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 400 Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth **Funeral** Days Month, Day, Year July 1, 1 Months Hours Min. Director 491-26-0895 87 2,3517 1 M 2 X F Usual Residence of Decedent should be filed within 72 nous and end Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show arke event, the Medical Examinar must be notified at 10b. Count 10c. City, Town or Location Director Maryland Montgomery Gaithersburg November 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 415 Russell Avenue, #316 20877 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County 2121 College (1-4 or 5+) Elementary/Secondary (0-12) Public Schools Teacher Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Finger Stella Reese 19a. Informant's Name/Relationship (Type, Print) thent of Health end trant: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas M. Campbell 1200 Meadow Green Lane, McLean, Virginia 22102 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State November 4 Donation 5 Other (Specify) Alexandria, Virginia 2012 21. Signature of Funeral Service (licens DeVol Funeral Home, 22. Name and Address of Facility M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 fart 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, not, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) Due to (or as a nsequence of): Examiner heumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or a consequence of): burial-transit ailyve or Attending Physician: The law requires that the death certificete be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physiclen s the burial Physician/Medical Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) as been signed by the atter in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hont tailure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 1 Yes 2 No **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 102 e and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, Suite 206, Roderile, Months, MD 31. Date filed (Month, Day, Year) Registrar's Signature State

3 Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Dav

20850

1 X Yes 2 No

Missouri

White

12:21 A M

DHMH 17 Rev 06-2011

Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

FOI	yland / Department		lental Hy	giene	00010
1 - State Registrar	Certificate	of Death		Reg. No. 2	38348
1. Decedent's Name (First, Middle, Last) Physician			2. Date of Dea	Day Year	
/Medical Dale Robert Caudel1 Examiner 4a. Facility Name (If not institution, give street and number)	4b. City. To	own, or Location of Death	11	04 2012 4c. County of Dea	
12601 Kemmerton Lane	Bowie	· ·		1	George Co.
tv M 2 □ E	(In yrs. last birthday) If Under 1 Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birt (Month, Da	th 9. Bi	rthplace (State or Foreign Country)
215-62-8179 51	Yrs.		07/07/1	.961 Mar	yland
10a. State 10b. County 1	Oc. City, Town or Location				10d. Inside City Limits
MD Prince George Co.	Bowie				1 □ Yes 2 🛣 No
10e. Street and Number	10f. Zip C			10g. Citizen of What C	ountry?
12601 Kemmerton Lane 11. Marital Status 12. Was Decedent Eventual Forces? 1 Never Married 2 Married 1 1988 285 No.	207			U.S.A.	porioon Indian
P		nt of Hispanic Origin? (Spe Cuban, Mexican, Puerto	Rican, etc.)		te, etc.
The solution of the solution o	1 ☐ Yes 2	☑ No Specify:		Specify: W.	hite
To the part of the	16a. Decedent's Usual (Give kind of work	Occupation done during most of worki retired)	ing	16b. Kind of Business	s/Industry
Elementary/Secondary (0-12) College (1-4or 5+)	Disabled	reurea)		None	
Del transpara de la compara de		18. Mother's Name	(First, Middle,	Maiden Surname)	
Toa. State 10a. State 10b. County MD Prince George Co. 10c. Street and Number 12c. Was Decedent Every Armed Forces? 1		Eleanor	Perreir	a Caudell	
19a. Informant's Name/Relationship (Type. Print)		Street and Number or Rura		-	Zip Code)
호 문 등 등 등 등 된 Linda Caudell-Feagan (Sister 20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,	Street Arl:	ington,	VA 22201 20c. Location - City o	r Town State
Linda Caudell-Feagan (Sister 20a. Method of Disposition 18 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	20b. Place of Disposition (Name cemetery, crematory or other	וועאו		•	
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Arlington Nat:	Address of Facility Adv	ent Fun	Arlington, eral Servi	VA
i as a sale a la		Lee Highway			22046
23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.		_	, ,	rrest,	Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition al. Pue to (or as a condition al.)	Aspiration	Phermi	inia		Oriset and Death
Examiner Due to (or as a c	consequence of):				
Sequentially list conditions, if any, leading to immediate Due to (or as a c	consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Life underlying Cause (Disease or injury that inlitated events resulting in death) Last Due to (or as a c					
	consequence of):				
inficate be of physician as the burning edical E					
IF FEMALE: 23c. If yes, outcome of				23d. Date of d	elivery
in the past 12 months? Image: Control of the past 12 months? 1 Live birth 2 1 Pregnant at 1 Pregn				Month	Day Year
7. the table of the table of the table of the table of the table of the table of the table of the table of tab			00 0011		
Part II. Other significant conditions contributing to death but n		se given in Part I.		obacco use contribute ves 2∏ x 3∏ F	Probably 4 🗌 Unknown
pleted by 7 2 2 should be 2 should be 2 should be 2 should be 2 should be 3 sh			24a. Was		
Completed Completed			autop perfo	sy prior to rmed? death?	
S S S S S S S S S S S S S S S S S S S		26. Place of Death	1 □ Yes (Check only o		s 2 No
examiner? Hospital: Inpatient	2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 I Nursing Hor	me 5 Aesid	lence 6 □Other (Sp	ecify)
The state of the		Work?	28d. Describe h	now injury occurred	
The state of the s	- At home, farm, street, factory of	1 ☐ Yes 2 ☐ No	28f Location (S	Street and Number or F	Rural Route Number
27. Manner of Death 1	 At home, farm, street, factory, of Specify) 		City or Tox	n, State)	ratal Fronto Nambol,
The first of the f	kamination and/or investigation, ir	the time, date and place, my opinion, death occurr	and due to the red at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
29b. Signature and title of certifier	7210	icense number		29d. Date signed (Mor	
Just)	1	34560		11/06	112
30. Name and address of person who completed cause of deat	th (Item 23a) (Type, Print)	Blod Sule	D Cont	m. Md. Z	0706
State Registrar 30. Name and address of person who completed cause of deat George C. Hay av Jr. M 31. Date filed (Month, Day, Year) 82. Registrar's	Signature A. Aparts				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Marianne Physician/ Casey Month Nov. ^{Day} 2012 Campbell 11:48 amM 6 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 578-96-9125 50 **Director** 1 □ M 2 🖾 F April 14, 1962 Washington, DC Usual Residence of Decedent ir then "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD Montgomery Rockville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 501 King Farm Blvd., #308 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 K Never Married 2 Married Completed by 21215-0036 Specify: White 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 end 2 should be filed within 72 ment of Health and Mental Hygiene. ent: If Item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Heath and Mental Hygien importent: If item Z7 is marked other theny injury or other treumetic event, The once. Assistant Manager Retail Sales Be aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Francis Casey Janet Cassidy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Casey/Mother 501 King Farm Blvd., #308, Rockville, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Noy, 12, 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Liceusee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ ulmoham disease or condition Medical resulting in death) Die to (or as a consolvence of): Examiner 5clcr051 Sequentially list conditions, Due to (or se a consequence of): If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 1 Yes 2 No 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 줊 Completed 1 ☐ Yes 2 MSNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{\text{Nursing Home}}} \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 1 No ၉ 1 Inpatient 2 KR/Outpatient 3 IDOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Aft

completely filled in by the fur death. 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D62553 November 2012 MC

Registrar

DHMH 17 Rev 06-2011

State

2

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ovember

asey

Medical

center Drive,

Rockville, nom

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1901

32. Registrar's Signature

Patsy meneil, Mb

NOV 08

31. Date filed (Month, Day, Year)

		For State Registrar		Cer	tificate of	Death		Reg. No. 201	2 38350
Physic	an/	1. Decedent's Name (First, Middle, La Agatha		Cowan			2. Date of De Month	Day V	3. Time of Death 4:35 P M
Med Exam		4a. Facility Name (if not institution, given	Kalanzis ve street and number)	-		or Location of Death	Nov.	2 2012 4c. County of I	
) LAGIII		Manor Care Poto			Potomac			Montgom	
Funera Directo		,	Sex 7. Age (In yrs. In 1		If Under 1 Year Months Days		8. Date of Bird (Month, Da	th y, Year)	Birthplace (State or Foreign Country)
		Usual Residence of Decedent	00				Oct.22	,1926 T	
ıryland a-f sho ied at	Director	10a. State 10b. County		y, Town or Loc lensing					10d. Inside City Limits 1 X Yes 2 □ No
the Ma or 288 e notif		Maryland Montgor 10e. Street and Number	liery K	ensing	10f. Zip Code			10g. Citizen of Wha	
s 23a	Funeral	5020 Nicholson L	ane		2	20895		USA	
r death or item uiner π		11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of F Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
rs afte iral", c Exar	ed by	3 X Widowed 4 Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates.	1	☐ Yes 2 🗶 No	Specify:		Specify:	Nhite
72 hou 1 "natu edical	Completed	15. Decedent's (Specify only highest of		(Give k	ent's Usual Occup kind of work done	during most of wor	king	16b. Kind of Busin	ess/Industry
vithin giene. er thar the M		Elementary/Secondary (0-12)	College (1-4 or 5+)		O NOT use retired, Lisher)		Columbia	Press
be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last, James Kalanzis)			18. Mother's Nar	, , ,	Maiden Surname)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.		19a. Informant's Name/Relationship William C. Redfe	Type, Print) Personal rn/Representati	19b. Mailin	g Address (Street Nicholso	and Number or Ru on Lane Si	ral Route Numbe	r, City or Town, State	, Zip Code) ton, MD 20895
of Head of Hea fitem		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of		Date	20c. Location - Cit	
Page tment o tant: If ijury or		1 Burial 2 🖾 Cremation 3 4 Donation 5 Dother (Spec	I Hemoval from State Me E	remato	tan tan ry	i Z	mber 6, 012		ia,Virginia
permit. Departn Imports any inju		21. Signature of Funeral Service Dice	For M00215			ess of Facility De ensin Ave		ral Home shington,	DC 20007
		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
Physician Medica		disease or condition resulting in death)	a. Advanced De						Shoot and Boar
Examine		Sequentially list conditions,	b. ————————						
ad add	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
axecuted in and ind-transit	1	that initiated events resulting in death) Last	C. Due to (or as a consequ	uence of):					1
ate be ex ohysician the buria	dical		d						
ath certifica attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date o	f delivery
r the atter	Completed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 【XNo 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		Ectopic pregnan Other (specify)	cy		Month	Day Year
requires that the des been signed by the a should be detached	by Pt	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying cause gi	iven in Part I.			e to the cause of death?
requir been s should	letec						24a. Was		e autopsy findings available
The law ate has page 2:	dmo						autor	osy prior ormed? deat	to completion of cause of
	Be C	25. Was case referred to medical examiner?				lace of Death (Che		2 E3 NO[Tes 2 NO
ertifica ector, p		1 Yes 2 X No	Hospital:	ER/Outpatien	t 3 DOA Oth	ner: 4 🗶 Nursing H	ome 5 🗆 Resid	dence 6 Other (S	pecify)
Physician: T this certifica and director, p	은 ::				28c Inius	n/ at	20d December	our injune consumed	
 Hospital or Attending Physician: The law requires that the death certificate be extended to the control of the co	Certificate: To	27. Manner of Death 1 Natural □ Accident □ Suicide □ Could not	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur worl M 1	ry at k?] Yes 2 □ No	28d. Describe h	ow injury occurred	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunitha Bhogavilli, MD 9801 Georgia Ave. Suite 1-17 Silver Spring, MD 20902

29c. License number

D0054566

29d. Date signed (Month, Day, Year) Nov. 6, 2012

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 7 2012

29b. Signature and title of certifier

3. Registrar's Signature

Castle, Charles Earl Jr. 11/05/12 1125
Division of Vital Records, P.O. Box 68760

			Please	Type or Prir						-		_	ole.		
			1 - For State RegistraMEND#5cerINF, 1	State of Ma						Mental H	, 0	dm 400 1		0005	. 1
			1. Decedent's Name (First, Middle, Las		<u> </u>	Cer	tificate	OIL	eatri	2. Date of D	Reg. N	0.2	-	3. Time of Death	h
и	Physicia Medi		CHARLES EA	RL CAST	LG	JR				Month		ay 2	rear D/C	1125A	М
and the	Exami		4a. Facility Name (if not institution, give	street and number)			4b. City, To	own, or	Location of Dea	th	40	c. County of			
	Funeral		Suburban Hospita 5-2017 - 376 - 9051 6.50		(In vrs. la	ast birthday)	Bet If Under 1	thes 1 Year	da If Under 24 Hr	s. 8. Date of B	irth	Monte		Ly lace (State or Fore	ian
	Director		217-36-9031 -217-36-9031	⊠ M 2 □ F		Yrs	Months	Days	Hours Mir	. (Month, E	ay, Year)		Count	Country)	
	nd how	٦	Usual Residence of Decedent 10a. State 10b. County		73	/, Town or Loc	cation			05/03	/193	9		:y1and Od. Inside City Lim	nite
	Aaryla 8a-f s tified	recto	Maryland Montgo	merv	R	ockvil.	16							1 ☐ Yes 2 🎛	
	n the N a or 2 be no	Funeral Director	10e, Street and Number			.0010111	10f. Zip (Code			10g. C	itizen of Wh	at Coun	try?	
	ath wit ms 23 must	ner	29 Windermere Cou			140.1		0852				nited			
9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	by Fi	11. Marital Status 1 ☐ Never Married 2 🕱 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 X		İ	f Yes, specif	y Cubar	n, Mexican, Puer	Specify Yes or No to Rican, etc.))-	14. Race - Black,	America White, e		
003	urs aft tural", al Exa	ted I	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2	X No	Specify:			Specify:	Whi	te	
21215-0036	72 ho n "nat Aedica	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give F	lent's Usual kind of work O NOT use n	done di	ition uring most of wo	orking	16b. I	Kind of Busi	ness/Ind	ustry	
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nd	e filed within 72 hours after death with the Manyland that hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)						18. Mother's Na	ame (First, Middle	, Maiden	Surname)			
Maryland	ould by d Mer mark matic		Charles 19a. Informant's Name/Relationship (Ty	Earl Cast	1e,					Anna		seph			_
Ma	d 2 sho alth an 27 is ir trau		Elaine R. Castle/			1				ural Route Numb Rockvill					
Baltimore,	ye 1 and 2 should be filed within 72 I t of Health and Mental Hygiene If item 27 is marked other than "n or other traumatic event, the Medi		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☒		20b. PI	lace of Dispos	sition (Name	e of		Date	T	ocation - C			
ţį	t. Page tment tant: tant:		4 Donation 5 Other (Specify		1	ropoli	tan Cr	rem.	11/	06/2012			ia,	Virginia	ı
Bal	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licens							Vol Fune			МТ	20977	
			23a. Part 1. Enter the disease, or comp	lications that aused to	the death					Dr., Gat c or respiratory a		rsburg		Approximate	
in F	hysician/		shock, or hear failure. List only or mmediate Cause (Final hea e or lition	e cause on each line.	oui	MORA	RN.	ر دکت	WRE				- 1.	Interval Between Onset and Death	
أمر	Medical Examiner		resulting in death)	a. Due to (or as a	conseque	ence of):		731	Liget						_
	/9	er	Sequentially list conditions, if any, leading to immediate	b. Oue to (or as a			CTICA	Vn	TH H	EMORIE	HA	45	- /	mont	5
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	eath certificate be executed attending physician and for use as the burial-transit	اڃا	resulting in death) Last	Due to (or as a	conseque	ence of):									
200	death certificate be ne attending physici ed for use as the bu	Physician/Medica		d					<u> </u>				+		
Box 68760	certific nding use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o								23d. Date	of deliver	v	
Box	ed ed	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at t 9 Unknown			Ectopic pre Other (spec					Month		Day Year	
P.O.	Ardening Physician; The law requires that the dea death ector. The this centificate has been signed by the a by the funeral director, page 2 should be detached to		g Unknown Part II. Other significant conditions co		t not resu	ıltina in the ur	nderlying car	use give	en in Part I.	23a Did	tobaccou	use contribu	ite to the	cause of death?	
S, F	signe ld be	d by					, ,							ably 4 🖾 Unkno	wn
ord	w require s been sig 2 should b	plete								24a. Was		24b. We	e autop:	sy findings availab	le
Rec	ate has	Completed		·							opsy ormed? 2 🔀 N	dea		ipletion of cause o	I
ta :	certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:				26. Plac	ce of Death (Che						
) (r this eral di	e: 10	1 ☐ Yes 2 🔀 No	1 X Inpatier 28a. Date of injury		R/Outpatient 28b. Time of		. Injury	4 L Nursing	Home 5 Resi			Specify)		
on .	Attencing Pnysician; The last death. ector. The this certificate he by the funeral director, page	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	Year)	injury	м	work?		200. Describe	now mjui	y occurred			
Division of Vital Records,	o Attences after death Di ector:	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At hon (Specify)	ne, farm, stre	et, factory, c	office		28f. Location (r Rural F	Route Number,	
<u> </u>	No the hospital of within 24 hours afre to the Funeral Discompletely filled in the formal of the formal of the formal of the filled in the formal of the filled in the formal of the filled in the formal of the filled in the filled in the formal of the filled in the fil		29a, Certifier 1 - Certifying Physi	cian: To the best of m	v knowle	idae death o	courred at th	ne time	data and place				on atoto	4	
	n 24 h n 24 h ne Fur pletely	Medical	(Check 2 Medical Examinonly one) 3 Certifying Nurse	er: On the basis of exa	mination .	and/or investi-	aation, in my	opinion v	 death occurred 	at the time, date	and place	 and due to 	the caus	se(s) and manner st.	ated.
, i	14		29b. Signature and title of certifier					icense r				te signed (A			
	X		(Short					D_{I}^{\prime}	3745		- 1	1/0)	1	2/01	
			30. Name and address of person who co					ive.	Bethes	da, Mar	vlan	d 2081	L7		
	Stat		31. Date filed (Month, Day, Year)	32. Registrar				_,.,,			,				
	Registra	ir	NOV 0.7 2012	Buch	A.	14									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 4:15 OVEMB Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 1 - M 2 X F 590-32-3271 44 **Director** Yrs 8-14-1968 Usual Residence of Decedent Show 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MIDLOTHIAN 1 ☐ Yes 2 🛣 No TXELLIS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 506 ROUNDABOUT DRIVE 76065 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) BANK MANAGER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EVERETTE HOARCE BROWN CAROL SUE HURST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 ROUNDABOUT DRIVE, MIDLOTHIAN, TX 76065 JOEL CURTIS/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-15-2012 ENNIS, TX TWIN OAKS CREMATORY Signature of Funeral Service Licensee M00981 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between PRESUMTIVE Onset and Death Immediate Cause (Final PULMONARY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 5 days ENTEROCOCIAL BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ATRIAL attending physician and for use as the burial-transit Exam that the death certificate be executed FIBRILLATION that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year the 9 Unknown 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 N 2 🗌 No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) : After this funeral c 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural 5 Pending injury s after death.

I Director: Aft
d in by the fur 1 Tes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours af

To the Funeral Di

completed filled in Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tj 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JM AGBOR-ENOH SEAN TABI 31. Date filed (M State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont Year LAMES 10:35 Medical а 4a. Facility Name (if not institution, give street and number) 🛴 Examiner 4b. City, Town, or Location of Death 4c. County of Death 9400 Croom Acres Drive Upper Marlboro Prince George's Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 24 Hrs. **Director** 266-22-7438 1 🛛 M 2 🗆 F 87 April 15, Georgia 28a-f show 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Upper Marlboro Maryland | Prince George's ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be 23a Funeral 9400 Croom Acres Drive 20772 United States ral", or items? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, by 1 Never Married 2 Married X Yes f Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify. Black "natural" Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) West Coast Concrete Elementary/Secondary (0-12) College (1-4 or 5+) 6th Private Payload Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental | marked c မ Ed Clarke Louise Clarke and li 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 9400 Croom Acres Drive Upper Marlboro, Md. 20772 Marsha Clarke-Everett/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 ■Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Nov. 4 Donation 5 Other (Specify) Brooksville, Florida Brooksville Cemetery 2012 22. Name and Address of Facility Signature of Funeral Service Licensee Stewart Funeral Home, Inc. tewo M00560 4001 Benning Road NE 20019 Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death - Physician/ 215135 disease or condition Medical resulting in death) Due to (or as a consequence of Examiner SPIRATION NEUMONY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine SOPHAGENZ burial-transit Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by DEMENTIA Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DRUWARY 24a. Was an After this certificate has autopsy 2/ No 1 Yes Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 26434 7 2012 35M 30. Name and address of person who compl of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov. 4, 2012 8:33 A M Lillian B. Carson Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 4501 Reamy Drive Suitland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours Director 579-05-7889 1 □ M 2 🛛 F 94 Aug. 22, 1918 DC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f Maryland Prince George's Suitland 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4501 Reamy Drive 20746 United States Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian þ 1 Never Married 2 Married Black White etc 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Housekeeper Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Newman Cox Mary Ellen Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Harris- Daughter 4501 Reamy Drive Suitland, Maryland 20746 Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery Landover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. Stewa Ti M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Dementia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation this certificate has autopsv performed? Yes 2 No the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 🔀 No 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 🛛 Residence 6 🗆 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Is within 24 hours after death.
To the Funeral Director: After 1 X Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D66658 November 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9470 Annapolis Road Suite 306 Rexford A. Babilah, MD Lanham, MD

DHMH 17 Rev 06-2011

State

Registrar

NUY

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 10c, tchd, r1s, 11/1/12 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 36 Mae helma eers 0730AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Taibot Hasputal at Easton Mcmorial Easton 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 220-28-0891 1 🗆 M 2 🕱 F 80 09-20-1932 | Maryland Usual Residence of Decedent 23a or 28a-f show than "natural" or items condeath with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Church Hill Md. 1 Yes 2 No Oueen Anne's -329 Square Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "heers, theima Funeral 329 Flat Iron Square Road 21623 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 14. Race - American Indian. چ 1 Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced Completed Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.

I is marked other than raumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Care taker 12 Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill f Health and Mental item 27 is marked o ည Joseph Webster Eliza Cheers Jane Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine C. Smith/sister P.O.Box 43. St. Leonard, Md. 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any Injury or o 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesterfield Cem. 11-03-12 Centreville, Md Funeral Service License 21. Signatu 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover Street, Easton, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Physician Serand Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day signed by the at d be detached f Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been siç r, page 2 should t Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of or Attending Physician: The law autopsy this certificate perform 1 ☐ Yes 2 ☐ No Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of nin 24 hours after death.

The Funeral Director: After in prietely filled in by the funer 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Division 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Cyntifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title g 29c. License number 29d. Date signed (Month, Day, Year) D0653815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2195 WASHINGTON ST EASTON MD 21601 RS3 UL/MOOD 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Amend Tem 9,	17 &18 per FHPle	ase Type or Print in Bla	ick Indelible Inl	k. Ensure All Copie	es Are Legible.	
WCHD JW 11/16	1 - State Registrar	State of Maryland /	Certificate of L	Death	Reg. No. 2012	38356
Physician Medica	T7 7	e, Last) Cohen		2. Date of Description	Day Year	3. Time of Death
Examine	Julia Mawor	n, give street and number) Health Case Cent		Location of Death	4c. County of Deat	
Funeral Director	5. Social Security Number 028-03-9861 Usual Residence of Decedent	6. Sex 7. Age (In yrs. last bit 1 ↑ M 2 □ F 92	rthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. 8. Date of E Hours Min. (Month, E November	c 7, 1917 Mass	hplace (State or Foreign untry) achuetts
he Maryland or 28a-f show notified at		Boston Boston	wn or Location		r_mas	10d. Inside City Limits 1 X Yes 2 □ No
with the N			10f. Zip Code Unknw	on	10g. Citizen of What Co	untry?
S = 19 v	Unknown 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	A Give 7/20/	13. Was Decedent of H	spanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036 within 72 hours after giene. eer than "natural", o, the Medical Exam	15. Decede	10di 01 Batos, / 1 7 7 -	a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	luring most of working	16b. Kind of Business/	•
Maryland 2 2 should be filed wi th and Mental Hygic 27 is marked other traumatic event, t	17. Father's Name (First, Middle,	Last) urice Tobias Cohen	Insurance Sa	18. Mother's Name (First, Middle	Life Insur e, Maiden Surname) unny Solov	ance
Mary d 2 should alth and M	19a. Informant's Name/Relations Steve Cohen		-	and Number or Rural Route Number		
Baltimore, sernit. Page 1 and Department of Hee mportant: If item my injury or othe noree.	20a. Method of Disposition X☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (20h Place	of Disposition (Name of ery, crematory or other place) Sos Valley M	Data	20c. Location - City or Los Osos,	
Baltimol permit. Page 1 Department of Important; If i any injury or once.	21. Signature of Funeral Service	M-00849	22. Name and Addres Lochstampf	or Funeral Home	e, Inc.	17260
Medical	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	End State Vas	not enter the mode of dying	g, such as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
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ox 68760 ath certificate be exattending physician for use as the bura		d				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burnarial Certificate: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death g ☐ Unknown	th 3 Ectopic pregnanc 5 Other (specify)	у	23d. Date of del Month	very Day Year
ords, P.O. Box requires that the death been signed by the atte should be detached for	Part II. Other significant condition	ons contributing to death but not resulting			tobacco use contribute to	
Division of Vital Records, tal or Attending Physician: The law requires re after death. 31 Director: After this certificate has been signed in by the funeral director, page 2 should be Completed.		, ,,	,	24a. Wa: aut per	opsy prior to o formed? death?	opsy findings available ompletion of cause of
ician: certific irector,	25. Was case referred to medical examiner?	Hospital:	Othe	ace of Death (Check only one)		
of Vision of Physic report of the To			Time of 28c. Injury	4 Nursing Home 5 ☐ Res at 28d. Describe	sidence 6 Other (Speci how injury occurred	fy)
ivision of or Attending Parler death. Director: After to in by the funers. Certificate:	1 Natural 5 ☐ Pendir 2 ☐ Accident Investi 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	gation not be 28e. Place of Injury - At home, fa	M 1 🗆	Yes 2 No 28f. Location	(Street and Number or Rur	al Route Number,
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certificate: To Be Comp		Physician: To the best of my knowledge,	death occurred at the time	, date and place, and due to the	own, State) cause(s) and manner as sta	ated.
the Hospita thin 24 hours the Funeral mpletely fille	(Check 2 Medical E only one) 3 Certifying 29b. Signature and title of certifier	xaminer: On the basis of examination and/one Nurse Practitioner: To the best of my known that the basis of th	owledge, death occurred at the	ne time, date and place, and due to	the cause(s) and manner as	stated.
1	Barbara M	oder Blucher CR		360	29d. Date signed (Month	, vay, Year)
JBJ 8+1	Barbara Na	who completed cause of death (Item 23a)	(Type, Print)	Street, Hage	nstown, MD	21740
State Registrar	31. Date filed (Month, Day, Year)	32. R gistrar's Signature	hours			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:10 P M Walter Cullum, Sr. 2012 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 19833 Jeffery Dr. Washington Hagerstown Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 10.1955 215-64-9186 57 Mary Land Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 🗌 Yes 2 💢 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must be Funeral 19833 Jeffery Dr. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Welder Welding Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Henrietta C. Rankin Harry Cullum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is r. any injury or at Barbara Cullum-wife 19833 Jeffery Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Cremtory 11-19-2012 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Yai complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death brus15 Immediate Cause (Final ulmonaru Physician/ disease or condition resulting in death) YEAY Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to jor as a consectience of Exami that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ex DOSUYE 1

✓ Yes 2

No 3

Probably 4

Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate Yes 2 🗷 1 🗌 Yes 2 🗌 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🗷 Residence 6 Cother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 ANatural 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
__Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and little of cartifier 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

TULL HOUSE

801

32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

IRFAN W. HASSEN

31. Date filed (Month, Day, Year)

NOV-15-2012

AVE. PEDERICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stanley Wayne	Col	e 1- For State	State of Maryla	_	artment of Heartificate of Dea		ntal Hyg	jiene	0.0	10 0005
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Medical Exam		Stanley	Way	ne	Col	e		Month Da November 2	y Year I, 2012	0618 hrs
		4a. Facility Name (if not ins 30411 Three Note	stitution, give street and nur ch Road	hber)		y, Town, or Location arlotte Hall	of Death		4c. County of St. Mary's	
Funeral		5. Social Security Number		7. Age (In yrs. Ia			der 24Hrs.	8. Date of Birth (N		9. Birthplace (State or
Director		214-58-175	56 1XM 2_F	58	Yrs. Mor	nths Days Hour		1-4-		Foreign Country) Maryland
any		Usual Residence of Deceder 10a. State 10b. Co		10c. City.	Town or Location					10d. Inside City Limits
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5-0036 fled within 72 hours after death with the Maryland offsene. other than "matural", or items 23a or 28a-f sho the Medical Examiner must he notified at once	Director	10e. Street and Number			10f. 2	Zip Code	CVI	10g.	Citizen of What	t Country?
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D36 thin 72 ne.	Completed	12	J-12) College (1-2	4015+)	7	river			10.	king
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21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medi-	o Be	19a. Informant's Name/Rela	ationship (Type, Print)		19b Mailing Addre	SS (Street and Nu	SOA	al Pouto Number	City or Town	W/15 State, Zip Code) 20132
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ore, sslan of Hea If ite		20a. Method of Disposition 1 Burial 2 Crem	mation 3 Removal from		Place of Disposition (No crematory or other place		0 0	ate 20	c. Location - C	ity or Town, State
		4 Donation 5 Oth	nef Specify	J 51				9-12 1	3ryanto	own Mi)
Balti permit. Departm Imports	A	21. Signature of Funeral Se	Hwkkly		22. Name a	nd Address of Facili	i 140	una Pa	1	MD 20108
Physician	4	23a. Part I. Enter the diseas failure. List only one c	se, or complications that gau	used the death.	Do not enter the mod	e of dying, such as	cardiac or re	spiratory arrest,	shock or heart	Approximate Interval Between Onset and
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be be	Medi	IF FEMALE:		itcome of pregr					23d. Date of de	alivery
lox 6876C eath certificate attending phys	ian/	23b. Was decedent pregnant past 12 months?	t in the 1 Live birt		2 Fetal deat		ic pregnancy		Month	Day Year
Box 6876(e death certificate the attending phy- ed for use as the b	Physician/M	1 Yes 2 No 9	Unknown 9 Unknow		other (S	pecify)				
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ted					-		1 Yes 2		Probably 4 Unknown re autopsy findings available
e law r e has b ge 2 sho	Completed							autopsy performed	prio ? dea	or to completion of cause of ath?
ital Recions: The certificate rector, page	ပ္ပ	25. Was case referred to me	edical	-		26.Place of Death	(Check only		No 1 ▼	Yes 2 No
Vita hysicia this ce al direc	S B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inp	patient 2	ER/Outpatient 3	DOA Other			dence 6 🗸	Other: Scene
n of ding Ph h. : After : funeral	cation:	27. Manner of Death 1 X Natural 5	28a. Date of (Month, D	Injury Pay,Year)	28b. Time of Injury	28c. Injury at Worl		d. Describe how	injury occurred	
r Attencer death	ficati	2 Accident	Investigation 28e Place	of Injury - At ho	me, farm, street, facto			f Location (Stree	t and Number of	or Rural Route Number, City
Div pital or ours aft cral Di	ertifi		Could not be determined (Specify)	,,	,,,,	, , ,g, c		or Town, State		or real reactions, only
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	edical C	29a. Certifier (Check only one) Certifyir	ng Physician: To the best of	of my knowledg	e, death occurred at the	ne time, date and pl	ace, and due	e to the cause(s)	and manner as	s stated.
To tl withi To tl	Medi	29b. Signature and title of ce	i Examiner: On the basis of and manner state	ted.		ny opinion, death of 9c. License number	curred at th			(Month, Day, Year)
		for worth &	Shull MA			O.C.M.E.			ovember 22	
80	ł	30. Name and address of pe	· ·	•	,					
· ·	ate	Pamela E Southal			niner 900 W. B		t, Baltimo	re, MD 2122	3	
Regist	CIL®	31. Date filed (Month, Cay, Yo	ZOZUIZ ZEA	strar's Signatur	J. Marrie					

Baltimore, Maryland 21215-0036 and Mental Hygiene. physician a Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene

1 - State Amended #5 perfuneral home 11/16/2012/ccdh/ba
Registrar

Registrar 38359 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOV . 20°1′2 1:07 P M Gloria Ann Countiss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mary's Park Hall 47800 Park Hall Road 212 62 035 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD **Funeral** Hours 10/29/1954 1 🗆 M 2 🕱 F **Director** 58 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No Park Hall MD St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20667 47800 Park Hall Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 X Married Specify: Black nan "natural", Medical Exan 1 Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Walter Reed Elementary/Secondary (0-12) College (1-4 or 5+) Medical Tech 12 Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Idolia Fenwick James Ellis Shubrooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other transon. 47800 Park Hall Rd. Park Hall, MD 20667 Benjamin Countiss/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holy Face Chu.Cem 11/9/2012 Great Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licens 38576 Brett Way Mechanicsville, MD 20659 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Dus-Wit Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 1 Yes 2 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PR-alon 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an death? Hospital or Attending Physician: The 124 hours after death.
 Funeral Director. After this certificate hetely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DDA 1 Yes ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred iniury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier NOVEMBER 5, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Youngsik Moon, 24435 Mervell MD 20636 MD Dean Rd. Hollywood. Registrar's Signatur 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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DI Side		Registrar 1. Decedent's Name (First, Middle,	ŕ		Cer	tificate	e of L	eath_		2. Date of Dea		12	38350 3. Time of Death
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Examin	er	Carroll Hospita	-					Location of inst			4c. Count	y of Death Carr c	11
Funeral Director		5. Social Security Number 219–34–7094	6. Sex 7. A	ge (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	; Year)	Cour	
	_	Usual Residence of Decedent 10a. State 10b. County		86	, Town or Lo	cation				Oct 18	, 1926		ryland 10d. Inside City Limits
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vith the 23a or st	Funeral Director	10e. Street and Number 9510 Rocky Rido	re Road			10f. Zip	Code	21	778		10g. Citizen of	What Cou USA	ntry?
death v ritems ner mu		11. Marital Status	12. Was Decedent Armed Forces	?						cify Yes or No- Rican, etc.)		ce - Americ	
ırs after ıral", oı I Exami	ed by	1 ☐ Never Married 2 ☐ Marr 3 🕱 Widowed 4 ☐ Divorced	ied 1 Yes 2 I If Yes, Give Year or Dates.	WWII	1	I ☐ Yes	2 💢 No	Specify:			Specif		ite
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh Deborah Crawfo		er		_				Route Number, Rocky			
ge 1 and it of Hez ilfitem or othe		20a. Method of Disposition 1 X Burial 2 Cremation		20b. Pl	ace of Dispo emetery, cren	sition (Nan	ne of ther place	e)		Date	20c. Location	- City or To	
permit. Pag Departmer Important: any injury once.		4 ☐ Donation 5 ☐ Other (S ₁ 21. Signature of Funeral Service Li		Key	sville 22	. Name an		i		/2012 ers-Dur	Keymar boraw I	<u> </u>	al Home
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Physician/		shock or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each lin	ite o	Neroca	rdu	il e	Ands	set	tin	551,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to for as	a conseque	ence (i):	tone	1 8	Dise	لمد	2			10 11 11
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director After this certificate I completely filled in by the funeral director, page	Medical (Physician: To the best o										
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Janice L. Cook P^{M} Nov<u>ember</u> 2012 Medical 3:13 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 189-34-6165 Director 68 1 □ M 2 🔀 F Aug. 10,1944 Pennsylvania Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Oueen Anne's Centreville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 152 Symphony Way 21617 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceuent 2... Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 🔀 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Menta Important: If Item 27 is marked any injury or other traumation once. ild be file Mental I 2 Charles Lingenfelter Iva Steward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence Cook / Husband 152 Symphony Way Centreville, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 05 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory, INC. 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a. Part 1. Enter the dyease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physic an/ disease or condition Medical resulting in death) Due to (or = equen a of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 W ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 2 X No Other: Mineratient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Hatural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 2 🗆 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 [only one Certifying Nurse Practitioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit

State Registrar

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30. Name and add

31. Date filed (Month, Day, Year)

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ed cause of death (Item 23a) (Type, Print)

2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Medical 10 4a. Facility Name (if not institution, give street and numbe 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 420 P11 AC Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Hours 12/9/1939 Country 227-48-9210 Director 1 2 M 2 D F 72 MD 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Anne Arundel Tracy's Landing 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23aFuneral 420 Leitch Rd. 20779 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 9 Completed by 1 Never Married 2 Married XIX No should be filed within 72 hours after 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 XXO Specify: "natural", **ॐ**Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Owner Operator Farm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edna Rose Edwin Perry Crandell and lisi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is 4101 Sea Bass Ct. Nags Head, NC 27959 Susan White daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/6/2012 Atlantic Crematory Glen Burnie, MD Signature of Funeran Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other 1 🗌 Yes 2 **X**No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director, After this 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 No Accident Investigation pletely filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 0605 of death (Item 23a) (Type, Print)

Registrar
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State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene D#8 per FH State of Marylar 11/19/2012 ACO HEALTH DEPT CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Physician/ atherine Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1731 Chesapeake Drive Edgewater Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July
June 29, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 217-56-3386 Director 1 □ M 2 🖺 E 62 1950 Maryland Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If Item 27 is merked other than "neture!", or Items 23a or 28e-f show amy injury or other treumetic event, the Medical Examinating Foundation once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏻 No Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1731 Chesapeake Drive 21037 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Manager Dining Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Ritchie Louis Cantler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1627 Shady Side Dr., Edgewater, Maryland 21037 Michael L. Streit / Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Kalas Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-5-2012 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Lig 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Par 1. Eyler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ne a stax Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of: attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Month Day eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached g Unknown 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 🗌 No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 $\cancel{\square}$ Residence 6 \square Other (Specify) 1 Yes 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b Signature and title of dertifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Page 1 an nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕱 R 4 ☐ Donayon 5 ☐ Other (Specify),	emoval from State St	Place of Dispo cemetery, cren Mary	sition (Na natory or S Cer	ame of other plac neter	ÿ Nov	9,2012		ocation - Cinklin,		_{vn, State} ssachusetts
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State Registrar		31. Date filed (Month, Day, Year) NOV 0 5 201	22 Ebajetraria Signa				LEGGLIC	-i, iai				
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100	Medic Examin		Paulette Ann Cla 4a. Facility Name (if not institution,	give street and number)		1	r Location of Death		4c. County	of Death
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9800	filed within 72 hours after death with the Maryland trai Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🎦 No		pecify Yes or No- p Rican, etc.)		e - American Indian, k, White, etc. White
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Maryland 2	ild be filed within Mental Hygiene rarked other than atic event, the M	Э								
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Baltimore,	. Page 1 and 2 sh iment of Health a tant: If Item 27 is jury or other trai		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		20b. Place of Dispo cemetery, cren Resth Memoria	sition (Name of natory or other place aven La Garden	s Nov.	Date 6, 012		City or Town, State
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	ر <i>ب</i>		30. Name and address of person w	o completed cause of de	eath (Item 23a) (Type, P	rint)	n BN	n Sim	114762	reght mo
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Oct. 20. 2012 18:48 Lenoira Mariae Connor Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Capital Heights Prince George's 6812 Central Avenue # 403 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min Director 1 🗆 M 2 🔼 F 578-58-0367 67 1945 Usual Residence of Decedent Oct. 20, Maryland Maryland 28a-f shov ms 23a or 28a-f shor must be notified at 10b. County 10c. City. Town or Location Director 1 X Yes 2 No Maryland Prince George's Capital Heights 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6812 Central Avenue # 403 20743 United States filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Examiner Black, White, etc ò ģ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black. Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) 12th Prince George's County College (1-4 or 5+) the Office Clerk Public Defender Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F Joseph E. Connor Mary Thompson other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Andrea Locks - Daughter 3604 Asher Street Upper Marlboro, Maryland 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placel 1 Durial 2 x Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 2012 Clinton, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Possible Stroke Medical Examiner Possible Myocardial Infarction Sequentially list conditions, if any leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Atheroscleritoc Heart Disease physician ar Due to (or as a consequence of): Physician/Medical certificate be Hypertensive Cardiovascular Disease P.O. Box 68760 nding r as E FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 1 L Yes 2 L 9 D Unknown the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hyperlipidemia Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Sarcoiodosis and Chronic Lung Disease Yes 2 X No 1 Yes 2 No the Hospital or Attending Physician: thin 24 hours after death.

the Funeral Director: After this certifical mpletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔼 No Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou

To the Funer

completely fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2077100 110 D22111 November 8, 2012 JM

State Registrar 8116 Good Luck Road #305 Lanham, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signatu

Thomas KO,

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Arlene Vrankin Draize 2012 11:42 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13708 Loree Lane Rockville Montgomery 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Days Min. Months Hours (Month, Day, Year) Country) Director 338-26-6316 1 □ M 2 K F 79 Yrs. Feb. <u>Illinois</u> 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 XNo Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13708 Loree Lane 20853 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 2 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Roland Vrankin Anita Marie O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 sh partment of Health a portant: If item 27 is y Injury or other trai William J. Draize/Husband 13708 Loree Lane, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any Injury or or 1 K Burial 2 Cremation 3 Removal from State Nov 2012 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility, Francis J. Collins Funeral Home Inc. 500 University Blvd. W,. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dermatomyositis Medical Examiner Due to (or as a consequence of): Anasarca since 2011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events sician and re burial transit Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed kecurrent Cellulitis since 2011 resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☒ No Pregnant at time of death Day 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe 1 be o Completed by Dehydration, Diarrhea page 2 should 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate | Completely filled in by the funeral director, pag 1 Yes 2 No 1 ☐ Yes 2 🗵 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 ₹ No 1 🗌 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 ☐ Accident work? 1 ☐ Yes 2 ☐ No 5 Pending injury Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 12 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number M ei

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JOhn McNeil, MD

NOV 08 2012

31. Date filed (Month, Day, Year)

D46584

12126 Heritage Park Circle, Silver Spring, MD 20906

November 7.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 38368 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Garland Manth _ 19 _ 19 Dunbar 0748 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 225-46-6180 Months Days Hours 1 M 2 □ F Director 9-1-35 Virginia Usual Residence of Decedent i Hygiene. I other than "natural", or items 23e or 28e-f show vent, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location Burtonsville with the Maryland 10d. Inside City Limits Director Md. Montgomery 1 XYes 2 ☐ No 10e. Street and Number 7 Alper Green Court 10f. Zip Code 10g. Citizen of What Country? 20866 Funeral USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 Specify. Black 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Golf Course of Health and Mental Hygie If item 27 is marked other ir other treumatic event, It Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental i Important: If item 27 is marked of any Injury or other treumatic eve once. Ethel Lee Branch Joseph Dunbar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shareef A. Mustafa / Son 7 Alper Green Ct, Burtonsville,Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plac Heritage Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 10-27-12 Waldorf, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 411 Kennedy St. N. W. Universal Mortuary Inc, Washington, D.C. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ACUTE MYOCARDIAZ INFARCITUN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner FAILURE SPIRATORI Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown HYPER CHOLES TEROL EMIN 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

22d Date signed (Month, Day,) only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) TODRIC D40324 OCTOBER 19, 2012 3.m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAROMA PARK. MD, FACEP AVENUE, JOORLE 7600 CAPPULL State Registrar

Amend 21 per FH G934 12/5/12/dk

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State Registrar

31. Date filed (Month, Day, Year)

NOV 1 2 2012

32. Registrar's Signature

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Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune	ral Service Licens	See A.		²²	Name and	d Address Foa	s of Facility rd Fi	une	ral Ho Chesa	ome_	, P.	Α.		
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09,	ss that the death certificate be ex igned by the attending physician be detached for use as the buria	gic			d		-								-		
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Ę	Physic this c	요 :	1 Yes 2 X	No	1 Inpa		ER/Outpatier 28b. Time of			4 🗀 Nurs		ne 5X Resi					
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sio	Atten deat ctor: by the	Įij	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	e 28e. Place of I	njury - At ho	me, farm, stre			163 2		28f. Location (Street a	nd Numbe	r or Rural	Route Numbe	er.
Division of Vital Records,	al or / s after I Dire		4 LI Homiciae	aeterminea	building,	etc. (Specify)						City or To					,
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	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 burns after death certificate has been signed by the attending physicis to the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	Me		Certifying Nurs	ner: On the basis of se Practitioner: To			death occi	urred at th	e time, date			the caus	se(s) and m	anner as s	tated.	ner stated.
_	To To I		29b. Signature and tit			٨		29c.	. License				29d. D.	ate signed			
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-	4		30. Name and addres	ss of person who c	completed cause of	death (Item	23a) (Type, P	rint)	_ Cı	211	ч	ElHon	W	<i>w</i> 3	11921		
1	Stat	e	31. Date filed (Month,	Day, Year)	32. Regis	ar's Signat	ure _	7	1.1	'C 3'	1	CINON		, 0			
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			Decedent's Name (First, Middle, Last)		simouto or i	304117	2. Date of Dea		3. Time of Death							
	Physicia Medic		Stewart W. Deal, Jr.				Novembe	er ^{Day} 12 20	12 2:00 a M							
	Examin	er	4a. Facility Name (if not institution, give street and number) Encore Turf Valley			r Location of Death		4c. County of D	eath ward							
	Funeral			yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	n g.	Birthplace (State or Foreign							
	Director			93 Yrs.	Months Days	Hours Min.	(Month, Day 01/24/1	; Year)	MD							
	nd how at	<u>ا</u>	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or L	ocation		01/24/3	.515	10d. Inside City Limits							
	Maryla 8a-fs tified	Director	MD Howard	Marrio	ottsville				1 ☐ Yes 2 🛣 No							
	h the I ka or 2 be no	al Di	10e. Street and Number		10f. Zip Code			10g. Citizen of What	·							
	ms 2: must	Funeral	1998 Arrington Road 11. Marital Status 12. Was Decedent Ever	- II C 10	2110		if . Vo No		d States							
9	or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	14. Hace - A Black, W	merican Indian, hite, etc.							
003	within 72 hours after death with the Maryland gleine: et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.		3X Widowed 4 □ Divorced If Yes, Give Year or Dates 194	12-46	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White							
-5	72 ho n "nat Aedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occup e kind of work done (DO NOT use retired)	during most of worl	king	16b. Kind of Busine	ss/Industry							
21215-0036	within giene. er tha , the l															
D D	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)					Maiden Surname)								
<u> </u>	should be and Ment is marker raumatic e		Stewart W. Deal, Sr. 19a. Informant's Name/Relationship (Type, Print)	10h Mai	lling Address (Street		Liddel	City or Town, State,	Zin Anda)							
	2 章 2 ·		Ronald W. Deal - son		2 N. Bali				21043							
altimore,	pe 1 and t of Heal if item or other		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State	20b. Place of Disp cemetery, cre	oosition (Name of ematory or other plac	ce)	Date	20c. Location - City	or Town, State							
Ħ H	Pag ant:		4 Donation 5 Other (Specify)						sville, MD							
Ba	permit. Departr Imports any injt		21. Signature of Funeral Service Licensee Them Collin - Within						mily FH Inc. y, MD 21043							
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	nter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between							
	hynician/ Medical		regulting in death)		to thrive	9			Onset and Death							
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	<u> </u>	iner	Sequentially list conditions, if any, leading to immediate Lause. Enter Underlying	nsequence of):												
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9 ×	th cert ttendir or use	ian/I	23b. Was decedent pregnant 23c. If yes, outcome of p	Fetal death 3		ру		23d. Date of	·							
. Box	requires that the death certilicate be ex been signed by the attending physician should be detached for use as the buria	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown	ie of death 5	Other (specify)			Month	Day Year							
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Vital Records,	has be	Completed					24a. Was a autop: perfor	sy prior	autopsy findings available to completion of cause of							
ř =	sician: The faw is certificate has bilirector, page 2 s		25. Was case referred to medical		26 0	ace of Death (Chec	1 Yes		Yes 2 No							
VIta	ysıcıan: is certific director,	To Be	examiner? 1 ☐ Yes 2 🗶 No Hospital: 1 ☐ Inpatient	2 ER/Qutpatie	LOth	or.		ence 6 🗆 Other (Sp	pecify)							
101	ing Ph		27. Manner of Death 1X Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Ye	28b. Time of injury	work	y at :?		w injury occurred	- //							
SIO	of the i	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury -	At home, farm, si		Yes 2 ☐ No	28f Location (St	reet and Number or	Ruml Route Number							
Division of	tal or / rs after al Dire ed in t		4 ☐ Homicide determined 200. Frace of injury building, etc. (S)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town		nara nodio namoon							
- :	in the Hospital or Attending Physician: to the Hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medica	Solution 20													
:	vithir To the	2	29b. Signature and hite of certifier	, moviedy	29c. License			9d. Date signed (Mo								
	15+		1 / L/- h			3821		Novembe	er 12, 2012							
	1UT		30. Name and address of person who completed cause of death Teizu Wolokolie P.O. Box 1	, , , , , ,	Print) ings Mills	s. MD 21	.117									
ľ	Stat Registra	e				_,										
	negistra	ग्रा		1. 0												

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Albert Edward Denis Jr. 11:21a.m. November 6, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Director** 020-40-1767 1**X**□ M 2 □ F 61 12/26/1950 Massachusetts show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director New 28a-f 1 Yes 2 No Hillsboro Milford Hampshire 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 9 Ash Street, Apt. 03055 United States r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Yes, Giv Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Software Engineer Computer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Albert Edward Denis Sr. Bertha Marie King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Ellen K. Denis/Wife Ash Street, Apt. 1, Milford, NH 03055 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr 11/09/2012 | Charlotte Hall, MD Signature of Experiment Service Insee

Michele Brinsfield M01652 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Cardiac Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examir that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical for use as the IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Vear Pregnant at time of death signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dath Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 124 hours arter consistence to Funeral Director: Af Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 28 2012 Lisa Douglas 10:14A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 12 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 212-86-0730 Director 1 □ M 2 🗓 F Oct 50 1962 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the May/and Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7703 Oakwood Rd. Apt 101 21061 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Decedent Ever Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Black, White, etc. 1X Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 11th None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lee Benjamin Douglas Mary Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Brown(Sister) 940 Master's Row Unit D Glen Allen, VA 23059 Baltimore, 20a. Method of Disposition 20b. [[f]lace of Disposition (b) ame of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State Memorial Gardens 11-9-12 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Miname Research Secilit Sons Mortuary, P.A. Lavy 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ therosuleratio disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, Examine fany leading to immedicause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No I∐Yes 2⊠No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 346 မ 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 💢 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MO 11/05/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McDowald State NOV U Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012										38375	
f	Physicia Medic		1. Decedent's Name (First, Middle, Last) Lorraine	Augusta	DeMe	esme		2. Date of Dea 1/17/02/		Year	3. Time of Death 3:20 A M
-	Examir		4a. Facility Name (if not institution, give st Ft. Washington Hos	,		4b. City, Town, or Ft • W	Location of Deat		4c. County Princ		orge's
	Funeral Director		5. Social Security Number 438-34-6033 Usual Residence of Decedent	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, Year) 1925	_ Count	lace (State or Foreign ry) Sanna
	aryland a-f show fied at	ctor	10a. State 10b. County Maryland Prince Go		y, Town or Loc					11	0d. Inside City Limits
	th the Ma Sa or 286 be notif	Funeral Director	10e. Street and Number		OII HII.	10f. Zip Code			10g. Citizen of V	/hat Coun	
980	filed within 72 hours after death with the Maryland tral Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funer	914 Forest Drive 11. Marital Status 1 Never Married 2 Married 3 🛣 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If	20745 Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🙀 No	ispanic Origin? (S n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		e - America k, White, e	tc.
21215-0036	ed within 72 hour. Hygiene. other than "natur ent, the Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation	(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired)	ation during most of wo		16b. Kind of Bu		
land 2	be filed v ental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, Last) John Boy	yd Sr.			18. Mother's Na	me (First, Middle, i			
Mary	should h and M 7 is mai traumat		19a. Informant's Name/Relationship (Type Roy DeMesme / S			g Address (Street a			*		
Baltimore, Maryland	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemoval from State	lace of Dispos emetery, crem	sition (Name of latory or other place	e)	Date 0/2012	20c. Location -	City or To	wn, State
Balti	permit. I Departn Importa any inju		21. Signature of Funeral Service Licensee		22.		es of FacilityGeo		alas Fu	neral	Home PA
j	Pnyuicianv Medical		23a. Part 1 Enter the disease, or complications, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	cause of Jeach line. PNEUMON	n. Do not ente					y rune	Approximate Interval Between Onset and Death
	Examiner	r.	Sequentially list conditions	Due to (or as a consequ	CLEROS	[S					
	ecuted and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							-
260	cate be executed physician and s the burial-transit	edical	L _d							\perp	
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Division of Vital Records, P.O.	The law require and the la										sy findings available pletion of cause of
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on of	nding Phy ath. r: After this ne funeral	Certificate: T	27. Manner of Death 1¾¾ Natural 5 ☐ Pending 2 ☐ Accident Investigation		28b. Time of injury	28c. Injury work	at	dome 5 Resident Resid			
Divisio	cal or Atters after de la Directo ed in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		et, factory, office		28f. Location (St City or Town	reet and Number n, State)	r or Rural I	Route Number,
_	he Hospit in 24 hour he Funera pletely fill-	Medical	(Check 2 Medical Examine	ian: To the best of my knowle r: On the basis of examination Practitioner: To the best of m	and/or investig	gation, in my opinio	n, death occurred	at the time, date an	d place, and due	to the caus	se(s) and manner stated.
	Not to the contract of the con		29b. Signature and (the of curtifier	~ MD		29c. License D 0069		2	29d. Date signed 11/02/2		ay, Year)
	dil.		30. Name and address of person who cor Nitinkumar Dosh			ston Rd.	Ft. Was	hington,	MD 20	744	
2'	Stat Registra	_	31. Date filed (Month, Day, Year) NOV 0 7 201	2 32. Pégistrar's Signatu	A. So	ake					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day William Edward Dennison November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cromwell center Baltimore Baltimore Colinti 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Sex 1 M 2 □ F (Month, Day, Days 220-40-3330 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21122 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. injury or other traumatic event, the Medical Examiner Armed Forces 9 1 Never Married 2 Married Completed by ☐ Yes | 2 No filed within 72 hours after imore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes. Give Specify: White 3
Widowed 4
Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental Important, If item 27 is marked of any injury or other trans ပ္ William Edward Dennison AnneBell Cartwright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Dennison/ Spouse 90 Circle Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Ft. Lincoln Cemetery 11/16/2012 Brentwood, Maryland Signature of Funeral Service Lensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd, Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each life. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be vision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death Month Day Year 1 ☐ Yes ∠ q 9 ☐ Unknown 9 Unknown signed by to d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cate has been signification to page 2 should to Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 1 this certificate had director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} မ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 5 \square Pending Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Siar 13 JM State Registrar

302

			For State of Maryland / Depa		Mental Hyg	iene an La	20277
				ificate of Death	F	leg. No. 4 U 4	38377
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	Day Year	3. Time of Death
	Medic Examir		June Katherine Dunn 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Novembe	r 15 201.	
			72 Fairview Road	E1kton		Cecil	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	thplace (State or Foreign untry)
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	/land f shoved at	ţoţ	10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
	Many 28a-	irec	Florida Citrus Beverly				1 🗆 Yes 2 🔀 No
	ith the	ral	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	*
	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Funeral Director	3600 West Cogwood Circle 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	34465 as Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	United S	
92	fter de ", or it amine	b	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 [X] No	Yes, specify Cuban, Mexican, Puerto □ Yes 2 🏹 No Specify:	Rican, etc.)	Black, White	
Ö	ours a atural	Completed	3 Widowed 4 □ Divorced If res, Give Year or Dates. 15. Decedent's Education 16a Decedent 16a Deced			Specify: Whi	
5	an "na Medic	Jd m	(Specify only highest grade completed) [Specify only highest grade completed] [Give kii] [Institute of the control of the c	nt's Usual Occupation nd of work done during most of work NOT use retired)	ring	16b. Kind of Business/Clothing	Industry
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Maryland 21215-0036	ould be filed within 72 hours after death with the Manyland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, N	flaiden Surname)	-
2	should be file h and Mental F 7 is marked o fraumatic eve	-	Howard F. Lindt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing		E. Kraft		
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Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 20b. Place of Disposi	tion (Name of	Date	20c. Location - City or	Town, State
Ĕ	Page 1 ment of 1 ant: If its ury or o		The Burner E GE Cromation of Enternoval normation	s & Co., Inc. 16.	mber 2012	West Che	ester. PA
galt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility $\dot{ extbf{Hi}}$	cks Home	for Funera	als, P.A.
	49 = 6 0		23a. Part Enter the disease, or complications that caused the death. Do not enter	103 W. Stockton			
	hysician/		shock, or heart failure. List only one cause on each line.		or respiratory arre		Approximate Interval Between Onset and Death
	Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	um a Colon			Unboand Death
	Examiner	<u>_</u>	Sequentially list conditions, b.				
	ed sit	mine	if any, leading to immediate Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury			- 3	
	xecute n and al-trar	Examiner	that initiated events c. Due to (or as a consequence of):				
20	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Birector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d				
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ă ă	the de ry the ached	hysi	1 Yes 2 No 9 Unknown 9 Unknown	other (specify)			
7. O	that 1 gned b se deta	by P	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.		acco use contribute to	
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Records,	law re has be je 2 sh	Completed			24a. Was ar autops	v prior to c	opsy findings available ompletion of cause of
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VItal	ysicia s certi directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check		nce 6 🛛 Other (Specia	Son's Residence
0	ng Pn ter thi ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe hov		W Residence
0	tendil Jeath. tor: Af the fu	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No			
DIVISION OF	after or Att	Cer	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	., factory, office	28f. Location (Str City or Town,	eet and Number or Rura State)	al Route Number,
ָנ	ospita hours ineral ly filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	curred at the time, date and place, a	nd due to the cau	se(s) and manner as sta	ited.
:	the Hin 24 the Fu	Mec	only one) 3 Certifying Nurse Practitioner: To the bast of examination and/or investig	ation, in my opinion, death occurred at eath occurred at the time, date and pla	the time, date and ace, and due to the	d place, and due to the co cause(s) and manner as	ause(s) and manner stated.
١	© 4 wit 0		29b. Signature and title of certifier achdev-5 MD	29c. License number	29	id. Date signed (Month,	
	10 cm		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	100000000000000000000000000000000000000		11.10.00	<i>"</i>
_	1 71		S. S SACHDEN MD 126A, E HI	29c. License number Doo23322 Sh St Ecklon	MD2192	4.	
	Stat Registra	-	31. Date filed (Month, Day, Year) - 39 Registrar's Signature				
	negistra	-	NIV 2 9 7017 Buch B. Bark				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2040 eona Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumber land If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 89 235-30-4433 Director 1 M 2 WF 03 1923 Wsst Virginia 09 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Allegany Frostburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral 21532 U.S.A. 300 Allegany Street or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Saltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. Elementary/Secondary (0-12) Celanese College (1-4 or 5+) Beaming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pearl Crowe Griffiths Thomas Griffiths 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer Durr Husband 300 Allegany Street Frostburg, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-19-2012 Frostburg, MD Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, Sowe Frostburg, MD 21532 MOQ54 60 W. Main St.. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) ementi Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 12 months? 3 Ectopic pregnancy 5 Other (specify) in the past 12 Month Day Year Pregnant at time of death been signed by the a should be detached Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 28c. Injury at Certificate: 5 Pending work? 2 🗌 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for tifying Nurse Practitioner: To the basis of my knowledge, ceath occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and til certifie 29d. Date signed (Month, Dav. Year) 12

Registrar

30. Name and

ddress of person who cor

NOMOR

31. Date filed (Month, Day, Year) NOV 2 9 20

600 Memoria Are Cumbe

death (Item 23a) (Type, Print)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 2

		-	For State Registrar	State of M	aryland / De Ce		te of D		ivientai riy	Reg. No	001	2	38379
ľ	Physicia	n/	1. Decedent's Name (First, Middle, Las	t)					2. Date of De		ay Ye	ar	3. Time of Death
and the same	Medic Examin	al	JOHN H. EPPLER 4a. Facility Name (if not institution, give	street and number)		4b. Cit	v. Town or l	ocation of Deat	OCTOBE		. County of E		11:15 A ^M
,	LAGIIII	٠.	TALBOT HOSPICE H	IOUSE			EAST				TALBO		
	Funeral Director		5. Social Security Number 6. Se 217–16–1904	7. Ag	e (In yrs. last birthday) If Und Months		1f Under 24 Hrs Hours Min.	(Month, Da	ay, Year)	- 1	Country	
			Usual Residence of Decedent	ZX IVI Z L.J I	113.				11/15/	192	1 1		LAND
	aryland a-f sh fied a	Director	10a. State 10b. County TALBO	Т	10c. City, Town or EAS							100	d. Inside City Limits 1 Yes 2 □ No
	the Mi or 28		10e. Street and Number				ip Code			10g. C	itizen of What	: Country	
	th with ns 23a must b	Funeral	28547 CONGRESSION				216				USA		
9036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hyglene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	ρ	11. Marital Status 1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 2 Yes 2 If Yes, Give Year or Dates.	Ever in U.S. 13		edent of His ecify Cuban 2 X No		pecify Yes or No- to Rican, etc.)	-	14. Race - A Black, V Specify:		· ·
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Maryland 21215-0036	To be to the position of the p										Surname)		
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Baltimore,	ge 1 ar it of He iffiten or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State		ematory or	other place	•	Date	l	ocation - City	or Tow	n, State
Ē	nit. Page artment c ortant: If injury or e.		4 ☐ Donation 5 ☐ Other (Specification of Feed Service Licenter)		CHESAPE						EVENSV		-
<u>8</u>	permit, Departi Import any inj		1 A Kent	Home	JCF5()	ELLO 200 S	WS, HE OUTH I	LFENBEI IARRISON	N & NEW	NAM EA	FUNERA STON,	L HO MD	ME, P.A. 21601
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Division of Vital Records,	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	_	4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, s c. (Specify)	treet, facto	ory, office		28f. Location (City or Tox			Rural Ro	oute Number,
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 3 Certifying Nurs	ner: On the basis of e	xamination and/or inv	estigation, i	n my opinion	, death occurred	at the time, date a	and place	e, and due to t	he cause	e(s) and manner stated
	To the H within 2. To the F complet	2	29b. Signature and title of certifier	e Fractitioner 15 th	spest of my knowledg		9c. License		place, and due to		e(s) and mann ate signed (Mo		
			Tomby (Calla	John		D	3146	6	_/	0/31	/12	
94	5+1YA		30. Name and address of person who c	ompleted cause of de			OOD DR	IVE, EA	STON, ME	21	1601		
رن	Stat		31. Date filed (Month Per Year) 1 2		er'o Signaturo 4	bar		-					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBE 2 Roy William Eversole 2:55 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Reeders Memorial Home Washington Boonsboro Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan 29 Hours 205-44-0807 58 1954 Pennsylvania Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Cascade 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25464 Military Road 21719 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Installer 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Theodore Eversole Freda Mae Wagerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 142, Rouzerville, PA 17250 Donald Eversole, brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Emmitsburg Memorial 11/1/2012 Emmitsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Ch 120 ~ c 035TRUCTIVE Medical Due to (or as a consequence of) DISRASA Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and impleted filled in by the funeral director, page 2 should be detached for use as the hurial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Yes 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 L 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury Accident
Suicide Investigation In 24 hour. the Funeral Directory and filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the comple 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 - ut mo D18019

Registrar
DHMH 17 Rev 7/2009

State

VERSOLE

STREET HAGERSTOWN MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RECLA

2012

VASANT

OCT 3 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 13:15 Pearl Doris Emerick 2012 Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frostburg Frostburg Village Nursing Home Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 KF Hours (Month, Day, Year) 08-01-1926 Maryland 86 213-24-5573 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location Director 1 Yes 2 X No Allegany Mt. Savage MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. Funeral 21545 Rt. 1 Box 193 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ò 1 Never Married 2 Married 1 Yes 2 No Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Bertha McKenzie Wagner 17. Father's Name (First, Middle, Last) ဂ္ Thomas Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12040 Tris Ave. Cumberland, MD 21502 daughter Mary Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Cumberland, MD Restlawn Mem Gardens 11-16-2012 | 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sowers Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60. W. Main St., Frostburg, MD 21532 MOQ5217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Dementia 5 tuge End months disease or condition resulting in death) Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? 1 ☐ Yes 2 KNo 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 🗌 Yes ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending

physician and the burial-transit death certificate be executed Division of Vital Records, P.O. Box 68760 signed by the attending p To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shor Examiner must be notified at

"natural",

ntal Hygiene. sed other than "natura c event, the Medical E

Page 1 and 2 should be filed within 72 hours after death

Mental marked

item 27

Department of Important: If it any injury or o

h_sician/

Medical

Examiner

other

Baltimore, Maryland 21215-0036

Certificate: 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifie

00055325

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WONSOCK SHIN 925 Bishop Walsh Rd Cumberland MD 21502

31. Date filed (Month, Day, Year, NOV 2 9 2012

29a Certifier

State

Registrar

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 23a per M.D. State of Maryland / Department of Health and Mental Hygiene														
V			For State Registrar	state of Maryla	na / Depa Cer	artment of F tificate of L	lealth and Death	Mental Hy	0.0	112 20283					
Ü	Discolation		Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death					
بيهشن	Physicia Medic	cal	13etsey J	. Forre	nce			Schobe		2012 2:00 AM					
	Examir	ier	4a. Facility Name (if not institution, give stree 17247 Annandale Road	đ			sburg			y of Death Frederick					
	Funeral Director		5. Social Security Number 6. Sex 19-68-8941	7. Age (<i>In yr</i> s.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year)	9. Birthplace (State or Foreign Country)					
	t wo	Ļ	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo	ation		May 5,	1936	Washington DC 10d. Inside City Limits					
	Marylan 28a-f st otified a	irecto	Maryland Frederic		ity, lowir or Lot	odion .	Emmi	tsburg		1 ☐ Yes 2 🕱 No					
	with the 23a or 3ust be no	Funeral Director	10e. Street and Number 17247 Annandale Road	i		10f. Zip Code	21727		10g. Citizen of	What Country? USA					
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	2	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates.		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Rac Bla Specify	ce - American Indian, ack, White, etc. y: white					
21215-0036	72 hour	Completed	15. Decedent's Educat (Specify only highest grade c		(Give I	ent's Usual Occupa	ation furing most of wo	rking	16b. Kind of E	Business/Industry					
212	within giene.	Con	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	1	Attorney			State	Government					
land	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Ellis Johnson 18. Mother's Name (First, Middle, Maiden Surname) Alice Lagasse												
Maryland	d 2 should alth and M 1 27 is mar er traumat	7	19a. Informant's Name/Relationship (Type, F			g Address (Street a ' Annanda .			-						
Baltimore,	Page 1 and of Her Int: If item Iny or othe		20a. Method of Disposition 1	20b.		sition (Name of natory or other place g Memoria		Date 26/2012		- City or Town, State					
Balti	permit. Departn Departn Imports any inju		21. Signature of Funeral Service Licensee	warodu	22	Name and Addres	s of Facility N	lyers-Dui mmitsbur	rboraw E g, MD 2	Funeral Home 21727					
	Pny inian Medical	- 5	23a. Part . Enter the disease, or complicate shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death)		eatit		g, such as cardiac creatic Car		rest,	Approximate Interval Between Onset and Dea					
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):										
	e executed sian and urial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):										
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Box	Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death certificate be a 24 hours after death. After this certificate has been signed by the attending physicis trely filled in by the funeral director, page 2 should be detached for use as the buse the bu	Physician/Medical	in the past 12 months?	If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnanc Other (specify)	у			ate of delivery onth Day Year					
P.O.	es that the dea signed by the a I be detached I	by Pt	Part II. Other significant conditions contrib	uting to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t		tribute to the cause of death?					
rds,	requires been sig should t	eted						1 🗆		3 Probably 4 Unknown					
Records,	The law rate has b	Completed						24a. Was autoj perfo 1 🗆 Yes	psy ormed?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
	ysician: The s certificate director, pag		25. Was case referred to medical examiner?	0-1			ace of Death (Che		2 20110						
of Vital	Physic this or	욘	1 Yes 2 No Hosp	1 ☐ Inpatient 2 ☐			4 ☐ Nursing I	Home 5 Resid							
	ending Phy aath. or: After thi the funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work' M 1		28d. Describe h	now injury occur	red					
Division	ital or Attendi irs after death. al Director: A lled in by the fi		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury - At h building, etc. (Specin		et, factory, office		28f. Location (S City or Tow		per or Rural Route Number,					
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical													
	o o vit		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)												
	AC.		30. Name and address of person who compl				0 11	<u> </u>	IM - "	land a series					
	\(\(\)	0	J. OMahony, M(31. Date filed (Month, Day, Year)	30 S	t Paul	Place	Dult	TITLEVE	riary	iana 11202					
	Stat Registra	re l	OCT 2.5 2012	Pierra.	A da	mel.									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Rosetta **Foley** 2012 2:19 A November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's 22680 Cedar Lane Court #1215 Leonardtown 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, Days 220-26-7127 **Director** 1 🗆 M 2 🔀 F Yrs. 83 11/2/1929 Maryland Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Leonardtown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 21885 Rosebank Road 20650 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Real Estate 12 Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Etta Jarboe Francis Leslie Cryer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 40194 Folly Cove Lane Leonardtown, MD Charles Michael Foley/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Francis Xavier 11/16/2012 Compton, Maryland of Funeral Service Licen Mattingley—Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ oncreation disease or condition Medical resulting in death) Du to (or as a consequence of) Examiner Sequentially list conditions Examine Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on burial-tran Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Tyes 2 HNo မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 Natural 5 Pending s after death. 1 Tes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajbinder S. Gill, M.D. 24035 Three Notch Rd., Hollywood, MD 20636 10 Rme 31. Date filed (Month, Day, Year) 32/Registrar's Signature NOV 1 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Edwin A. Feinberg November 10:10p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Citizens Care and Rehabilitation Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 130-26-4146 1 ☑ M 2 ☐ F 80 July 28, 1932 New York permit. Pege 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Heelth and Mental Hygiene.
Importent: If Item 27 is merked other than "natura!"
ery injury or other treumetic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 315 West College Terrace 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. <u>۾</u> 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Korean 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ₺ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retailer Office Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Elihu Feinberg Mildred Blair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Feinberg 315 West College Terrace, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Mt. Ararat Cemetery Nov.6,2012 Farmingdale, New York 21. Signature of Europal Service Ligensee 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hoepitel or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after deeth.

To the Funerel Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the burlet-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 Pregnant 9 Unknown Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed' 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 110 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/4/ TOLL HOUSE FREDERICK, MD

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Alice Mae Frisby Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 216-22-6565 Director 1 🗆 M 2 🗙 F 04-11-1925 Maryland Usual Residence of Decedent 10a. State at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notifled 28a-f 1 Yes 2 No MD Allegany Frostburg 10e. Street and Number 10f. Zip Code 2 10g. Citizen of What Country? pe 23a ral", or items 23/ Examiner must 17226 Luznar Lane SW 21532 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?. 1 Yes 2 No Black White etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give "natural", Specify: Black 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Help Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Green Waites Douglas Waites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 17226 Luznar Lane SW Frostburg, MD 21532 Robert E. Frisby husband 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place Cumberland Crematory 11-15-2012 | Cumberland. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home. 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death antio mular Physician/ perten sive Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or): attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months? 1 Yes 2 No Month Day signed by the at the detached for 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. I Director: After t 28d. Describe how injury occurred 1 Natural To the Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

32. Registrar'

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		For		State of M	1arylan		artment of H		nd N	lental Hy	giene	Э		
		State Registrar				Cei	tificate of L	Death			Reg. No	0.20	2	38387
Physicia	n/	1. Decedent's Name		,						2. Date of De		av ,	Year	3. Time of Death
Medic	al	An Facility Name of	DARI		GIBE	BS	T			ÖC'	$\overline{}$	8, 20		6:10 A M
Examin	er			ive street and number)		TTI A T	4b. City, Town, or		eath			County o		onaria
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eath y	Funeral Director	11. Marital Status	DAMICLING	12. Was Decedent	Ever in U.S	S. 13. \	Was Decedent of H f Yes, specify Cuba		? (Spe	cify Yes or No-	.	14. Race		ın Indian,
fter d ', or i	by	1 Never Marri		d Armed Forces' 1 ☐ Yes 2 X If Yes, Give) No		f Yes, specify Cuba 1 \square Yes 2 X No		uerto I	Rican, etc.)			White, e	ic.
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should and Me rs mar raumati		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Number o	r Rura	Route Numbe	er, City o	r Town, Sta	te, Zip Co	ode)
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ge 1 and 2 should be filed within 72 hours after death 11 of Health and Mental Hygiene. If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mu		20a. Method of Disp 1 XBurial 2		Removal from Stat		Place of Dispo emetery, cren	sition (Name of natory or other plac	:e)		ate	20c. L	ocation - C	City or Tov	vn, State
it. Pa			5 Other (Spe	**	FT		COLN CEM.			-2012				D, MD.
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once.		21. Signature of Fur	neral Service Lic	ensee	Dung	0091	Name and Address	FUNERAI	LH	OME & O	CREM	ATORI	UM,P	.A.
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Medical		disease or condition resulting in death)	n 🔏	Due to (or as	a consequ	ence of):	saflu	- Dys	70	ue			\dashv	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	Medical Exa	hysician: To the best of miner: On the basis of	examinatior	n and/or invest	tigation, in my opinio	on, death occur	red at	the time, date	and place	e, and due to	o the caus	se(s) and manner stated.
ithin a	Š	only one) 3 29b. Signature and t		urse Practitioner: To t	he best of n	ny knowledge,	death occurred at t	number			204 De	to signed (Month D	ou Voorl
5			Dan	300	_			102	_		10-	-30-	- 20	217_
		30. Name and date	ss of person wh	o completed cause of	death (Item	23a) (Type, F)				0	-	
		Ivan	Zan	na 30	01	HOS	oital-	DR .	0	DEVER	14	me	2	012
Stat		31. Date filed (Month		32. Regist	rar's Signat	ture	11.	,		-				
Registra	ir	NUV	07 201	6 Sevena	<i>A</i> .	Mari								

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 0 Physician/ Year 2011 NOVEMBER 22:16P M GRIMSLEY AMES Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE C((UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 241-44-5810 Director 1 🖾 M 2 🗆 F 79 08/26/1933 NC permit. Page 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "neture!", or items 23e or 28e-f show eny Injury or other traumatte event, the Medical Examiner must be notified as 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard Ellicott City 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9312 Rock Meadow Drive 21042 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 1954-55 Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Retail District Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Delmas Grimsley Mary Bernice Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9312 Rock Meadow Drive Ellicott City, MD 21042 Ora Lee Grimsley - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) remation Center of MD 11/17/2012 Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Live R Thomas Lana 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WAELOID Physician/ ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) After this certificate has been signed by the attending physiclan and funeral director, pege 2 should be detached for use es the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Dav g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GR EENE BALTIMORE, MD 0 SOUTH 1EMILOLU 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar			State c	of Mary	land /			e of E		and N	/lental Hy	/gien Reg. N	40 100	12	3	8390
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Examin		4a. Facility Name (if 418 W. V		-		nber)				Town, or	Location	of Death		- 1		ty of Death		
Funeral Director		5. Social Security No. 218–50–4	681	6. Sex	M 2 X F	7. Age (In y	rs. last t		If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year		Cou	nplace (S intry) rylai	tate or Foreign
yland -f show ied at	ctor	Usual Residence of 10a. State	10b. County				. City, To	own or Loca					00/17/	174		Hai	10d. Insi	de City Limits Yes 2 \(\sigma\) No
th the Ma 3a or 28a t be notif	al Director	Maryland 10e. Street and Nun					ager	stown	10f. Zip			-				What Cou		A Yes 2 No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	418 W. W		12	2. Was Dece Armed Fo	edent Ever in	n U.S.	13. W	as Dece	21742 dent of His cify Cubar	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)			ice - Amer ack, White		an,
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2 should Ith and M 27 is ma traumat		19a. Informant's Na	ame/Relationsh	ip <i>(Typ</i> e,	Print)						ınd Numbe	er or Rura	1, Hag	er, City	or Town,			0
age 1 and int of Hea t: If item / or other		Lorraine 20a. Method of Disp 1 🔀 Burial 2	oosition Cremation	3 🗌 Re		State 20	b. Place ceme	e of Dispos etery, crema	ition (Nar atory or c	ne of other place	e)	ı	Date	20c.	Location	- City or 1	Town, Sta	ite
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Physician/ Medical Examiner		disease or condition resulting in death)	on	f a.	Due to ((or as a con	sequenc	ce of):		0	ne	1701	RRH1	14			I M	ONTH
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Hospital o	Medical C	29a. Certifier 1 (Check 2	☐ Certifying	Physici: xaminer	an: To the b	est of my ki	nowledg	je, death od	ccurred a	t the time	, date and	I place, ar	nd due to the o	cause(s)	and mar	nner as sta	ited. ause(s) ar	nd manner stated.
To the within 2 To the I complete	Me		Certifying			: To the best	t of my ki		death occ		ne time, da			the cau 29d. E	se(s) and Date signe	manner as ed (Month,	stated. Day, Yea	ar)
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JW-3 State

Registrar DHMH 17 Rev 06-2011

		•	State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Reg. No. 2 0 2	38391									
П	Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death									
1	Medic	al	Jennieve Daniel Gilloory Nov. 7 2012	11:00A M									
and for	Examin		6895 Arbor Lane Bryans Road Charles										
	Funeral Director		412 18 2323 Months Days Hours Min. (Month, Day, Year) Country	ace (State or Foreign y)									
			Usual Residence of Decedent 90 Yrs. 11/22/1921	KY									
	arylano a-f sho fied at	ector	b 10a. State 10b. County 10c. City, Town or Location Bryans Road	od. Inside City Limits 1X Yes 2 No									
	the Man or 28	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Count	ry?									
	ith with ms 23a must I	nera	6895 Arbor Lane 20616 USA 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-										
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2X No	tc.									
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Maryland	should be filed within 72 n and Mental Hygiene. 7 is marked other than " raumatic event, the Mec	입	MITITUM BOULD BUILD I										
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Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Tov	vn, State									
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	AND MARKET		shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death									
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x 68	h certifi tending or use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delive	-									
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_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	Medical Certificate:	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as state (c) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as state (c) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (c) Medical Examiner: On the basis of examination and occurred at the time, date and place (c) Medical Examiner: On the basis of examination and occurred at the time, date and place (c) Medical Examiner: On the basis of examination and occurred at the time, date and place (c) Medical Examiner: On the basis of examination and occurred at the time, date and place (c) Medical Examiner: On the basis of examination and occurred at the time, date and place (c) Medical Examiner: On the basis of examination and occurred at the time, date and date (c) Medical Examiner: On the basis of examination and occurred at the time, date (c) Medical Examiner: On the basis of examination	se(s) and manner stated.									
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	16		1 x Marin D28352 11-812										
0	2-1-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 05 Da V.S Road Wald OYF MD 20	103									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5 Barry Avenue Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 1**X**] M 2 □ F 522-36-5176 78 10/6/1934 Colorado permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 ☐ Yes 2 🗓 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Barry Avenue 21403 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 X Yes 2□No Specify: Mexican Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Lieutenant Commander US Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Toney Aragon Charlie Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Hanna-Gomez/ Wife 5 Barry Avenue, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 11/10/12 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Furleyal Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final PARKINSON'S Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Day Month 1 Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CEREBRO VASCULAR ACCIDENTS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? LYMPHOLYTIC CHRONIC LEUKEMIA 24a. Was an autopsy ATRIAL FIBRILL ATION 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40 D 14774 11-6-2012 445 Defense Highway Annapolis, MD 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D SHAHID 4212 31. Date filed (Month, Day, Year) 32. Pégistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Doris Kathryn Gallagher November 2012 1023 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Ceci1 Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 221-20-6459 1 M 2 X F 81 OCT 23, 1931 Illinois 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified F1orida 1 X Yes 2 No Seminole Lake Mary 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 304 Old Mary Cove 32746 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 □ Divorced White Year or Dates is marked other than "natural aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Naturopath Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John J. Ulrich Eleanor Schamne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene M. Linke/Daughter 304 Old Mary Cove, Lake Mary, FL 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. T cemetery crematory or other place)
Tmmaculate
Conception Cemetery 1 X Burial 2 Cremation 3 Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cherry Hill. 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Physician/Medical Examiner If any leading to I minedicause. Enter Underlying Cause (Disease or injury that initiated events and the burial-tran resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death Unknown Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 mo Month 1 Yes 2 4 9 Unknown Yes 2 No been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 Funeral Director: After this certificate has autopsy death? 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 223

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)-

KYATEL MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23a per med cert 6936 2/25/13 dk.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 4 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year 1:22 PM Thelma Anita Gasparovic Medical November 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 14800 Cactus Hill Rd. Accokeek Prince Georges 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 213-44-3800 1 □ M 2 🔀 F Director 97 06/07/1915 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Prince Georges Accokeek MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral United States 14800 Cactus Hill Rd. 20607 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, Give Black, White, etc. Il Hygiene. other than "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Housewife 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked c 2 Howard Bertram Hoskins Mary E. Wissner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2608, La Plata, MD 20646 Gary S. Gasparovic/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/13/12 Alexandria, VA Crematory ature of Funeral Service Licenses 22. Name and Address of Facility Raymond Funeral Svc., P.A. any i M01517 5635 Washington Ave., La Plata, 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Demos Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 2 Accident 5 Pending work 1 ☐ Yes 2 ☐ No the f Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C

completely filled Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) allere

Registrar DHMH 17 Rev 06-2011

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

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30. Name and address of person who completed cause of death (Item_23a) (Type, Print) Dovis

Kood

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 14:48 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death of Mary land Medical Center Baltimore Uni Versity N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 220-94-5783 Director 1 ፟ M 2 ☐ F 46 Mar 23, 1966 Maryland Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll 1 Yes 2 No MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 67 Warfieldsburg Rd. 21157 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Mason/Bricklayer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joan Brothers Charles Richard Gist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1536 Deer Park Rd. Finksburg, MD 21048 Keli Houle/Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 11/17/12 Winfield, Maryland 4 Donation 5 Other (Specify) South Carroll Crematory 21. Squature of Funeral Service Lipenses 22. Name and Address of Fac Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Pare. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Cirrhosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death 5 Other (specify) cate has been signed by the apage 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director. After this certification of the Funeral Director. After this certification by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check onfy one) 8 (<u>P</u> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation

State Registrar

Medical

29a. Certifier

Candale

31. Date filed (Month, Day, Year)

NOV 2 9 2012

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Greene

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Phusician

22 South

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NOV 15, 2012

Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nelson ам Hammerley, Jr. November 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12704 Turkey Branch Parkway Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 579-40-7967 **Director** 1 ₺ M 2 🗆 F 81 Sept. 25, 1931 Washington, DC Usual Residence of Decedent 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12704 Turkey Branch Parkway 20853 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 1951-55 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Presentation Director permit. Page 1 and 2 should be filed wir Department of Health and Mentai Hygie Important: If item 27 is marked other any injury or other traumatic event, ± once. Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ E. Nelson Hammerley E. Marjorie Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene M. Hammerley/Wife 12704 Turkey Branch Parkway, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Nov. 6 2012 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service License 22. Name and Address of Facility. Francis J. Collins Funeral Home 500 University Blvd. W, Silver Home Inc. 1ver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Acute Myeloid Leukemia mos Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): s burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pt for use as tl IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autonsy performed? Yes 2 🖾 No this certificate 1 ☐ Yes 2 ☐ No nin 24 hours after death.

the Funeral Director: After this certific
npletely filled in by the funeral director, or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 🖾 Residence 6 Chter (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Hospital o 24 hours af e Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I complet 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01 D60335 November 6,

State Registrar

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 06-2011

acres

18111 Prince Philip Drive, #237, Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Bannen, MD 18111 Prince Philip

31. Date filed (Month, Day, Year)

NOV 07 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#1perMD, 11/8/12; EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) MARYELLEN HAGA 2. Date of Death 3. Time of Death Physician/ 2012 Month NOV. Day 3:55 P^M MARIELLEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min (Month, Day, Year) Director 204-28-3411 1 M 2 TF 74 JUNE 23,1938 PA. Usual Residence of Deceden show ral", or items 23a or 28a-f sho 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD. PRINCE GEORGES RIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4613 MADISON ST. 20737 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 N Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 NURSE NURSING permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN **SCHUBAUER** MILDRED DIEHL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KASMER DENKA/HUSBAND 4613 MADISON ST., RIVERDALE, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 11-9-2012 RIVERDALE, MD. . Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. Chambel 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burner transit Hospital or Attending Physician: The law requires that the death certificate be executed lowsk that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifice.

Sompletely filled in by the funeral director, the 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 힏 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 🔲 Yes 2 🗆 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) person who completed cause of death (Item 23a) (Type, Print) # 216, ROCKVILLE, MD 20852 Rando 1 RA ph led (Month, Day, Year)

State

Registrar

07 2012

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 201^{Year} 1:30am Dolores D. Harper Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕏 F Days Hours Director 08//36/TY933 Virginia 228 42 0466 79 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location **Funeral Director** 10d. Inside City Limits 1 Yes 2 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 West Side Drive, #201 20878 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔁 No Specify should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes Give Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Media Specialist PG County School Sys. years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Jackson Henry Douglas t. Page 1 and 2 should be tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) West Side Dr., #201 Rolanda Harper Gaithersburg, MD Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State Forest Hill Cemetery 11/10/2012 Lynchburg, Virginia ignat of Funeral Service 22. Name and Address of Facility John T. Rhines Funeral Home 20017 3005 12th Street, NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Myocardial Infarction minutes Medical resulting in death) Due to (or as a consequence of) **Examiner** Peripheral Vascular Disease years Sequentially list conditions, Disk to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 No
9 ☐ Unknown 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performe death? Yes 21 No certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: ျ 1 Inpatient 2 B ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Manner of Death 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After the pleted filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work __ Accident 1 🗌 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

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completed fi 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009

State

1054

29b. Signature and title of certifier

Brett Gamma, MD

D51980

Center Drive, Rockville, MD

MO

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901

29d. Date signed (Month, Day, Year)

November 1, 2012

20850

Box 68760 P.O. Records, Division of Vital 24 hours a Hospital To the I within 2

DHMH 17 Rev 06-2011

State Registrar 29b. Signature and title of certifie

31. Date filed (Month No.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Bramble

29d. Date signed (Month, Day, Year)

Combridge MO

2 Medical Examiner: On the basis of examination a local introduction of the cause (s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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		_	Registrar		Cer	tificate of	Death		Reg. No. ZU	12 38401	
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-	* Examin		81 Farmdale Dr.				eville	aut	4c. County of		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea Months Days	r If Under 24 H		th	9. Birthplace (State or Foreign	
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	± 0 0	Funeral Director	MD Cecil Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What C								
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Maryland 21215-0036	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ William L. Hael						r, City or Town, Stat		
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Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otl		1 X Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cren	natory or other pla		/14/12		Hill, PA	
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1	Physician/		shock, or heart failure. List only on Immediate Cause (Final disease or condition	ause on each line.		Stomar	ch Ca	nlen		Interval Between Onset and Death	
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0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner		(,,-						
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687	certif anding use a		Zob. Was decedent pregnant	3c. If yes, outcome of pregna		le.			23d. Date of	of delivery	
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Division	Atter	J. Tit	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he		et, factory, office				or Rural Route Number,	
Θ	tal or rs aftu al Dir led in			building, etc. (Specify	y)			City or Tow	n, State)		
	Hospi 4 hou Funer	Medical	29a. Certifier 1. Certifying Physic 2 Medical Examine	ian: To the best of my know	rledge, death o	ccurred at the tin	ne, date and place	e, and due to the ca	use(s) and manner	as stated. the cause(s) and manner stated.	
	thin 2 thin 2 the i		only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of	my knowledge,	death occurred at	the time, date and	d place, and due to the	ne cause(s) and man	ner as stated.	
	5 W W 00		29b. Signature and title of certifier		410	29c. Licens			29d. Date signed (A	1	
	•		30. Name and address of person who cor	noleted cause of dooth (Hear	MD	rint) At 1 4 +	V006	7 1/14	N MAK	110	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 per FH G935 1/07/2013 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3840 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nonth Nembe ZO12 Julia Lorraine HUTZELL 7:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown 2016 Security Number 1 Year If Under 24 Hrs. If Under Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth Hours Min (Month, Day, Year) Month 217-46-6583 **Director** 1 M 2 X F 67 Feb. 17, 1945 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director notified 1 Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Examiner must be items 23a 10831 Coffman Avenue 21740 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black White etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Yes 2 X No white If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ລe filed wns. ∸al Hygiene. `∾r than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other transmitted. 12 hairdresser beauty shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Lenuel Cash Clara Julia Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson Hutzell - husband 10831 Coffman Ave. Hagerstown, Maryland 21740 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 11/16/2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) MINNICH FUNERAL HOME of Funeral Service Lice 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. hnonic disease or condition Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): burial-t Physician/Medical Box 68760 nding physics as the l use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has te 2 autopsy page certificate Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural injury 5 Pending work?
1 Yes 2 No thin 24 hours after death. the Funeral Director: Af mpletely filled in by the fu death. M Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 the the only one within To the

Registrar

State

2

TW-5

29b. Signature and title of certifie

cause of death (Item 23a) (Type, Print)

29c. License number

Northern

29d. Date signed (Month, Day, Year)

21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(enneth Hardesty,	1- For State Registrar Certificate of Death Reg. No. 202	3840							
Physician Medical Examine		of Death 4 hrs							
	4a. Facility Name (if not institution, give street and number) Calvert Memorial Hospital 4b. City, Town, or Location of Death Prince Frederick Calvert								
Funeral Director	1 1 1 2 F Yrs. 1 1 9 6 7 Country)	State or RYLAND							
ĥ		side City Limits							
Aaryland 28a-f show	MD ANNE ARUNDEL LOTHIAN 1 109. Street and Number 109. Citizen of What Country?	Yes 2 XNo							
ith the Maryland 23a or 28a-f sho notified at onc-	184 B COURT 20711 UNITED STATES								
r death w	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify:	in, Black, E							
5-0036 led within 72 hours after the within 72 hours after the within 72 hours after the formula for the Medical Examiner Commission by									
de within ygiene.	BUILDING S	UPPLY							
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	17. Father's Name (First, Middle, Last) CARROLL E. HARDESTY, SR. 18. Mother's Name (First, Middle, Maiden Surname) MARGARET A. TIPPETT HARDE MARGARET MARGA								
MD 2 nd 2 shou alth and 1 m 27 is r	PHYLLIS S. HARDESTY / WIFE 1731 MARYLAND AVE., SHADYSIDE, MD 2	20764							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical) TO Be Compuler	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, OAKLAND CEMETERY 20c. Location - City or Town, St WALDORF, MD								
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<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause								
nted d ansit Examiner	(Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
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Box e death c the atten ed for us	FeMALE: 23b. Was decedent pregnant in the past 12 months? 1								
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Division of Vital Records, talor Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be artification: To Be Completed	24a. Was an autopsy prior to completion prior to completion doubt?								
I Rec n: The I rtificate b or, page	24a. Was an autopsy findings availab prior to completion of cause of death? 25. Was case referred to medical 26. Place of Death (Check only one)								
Wital Physician: or this certif	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other.								
ion of V tending Ph eath. tor: After the the funeral									
Divis tal or At ral Direct lled in by	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 22e. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	Number, City							
Division of Vital Records, P.O. Box 6876. To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the the Medical Certification: To Be Completed by Physician/Me	29a Certifier	s)							
	29b. Signature and title of certifier 29c. License number O.C.M.E. November 21, 2012	Year)							
BU-14	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
State Registra	te 31. Date filed (Month, Day Year) C 2012 32. Registrar's Signature								
	The state of the s								

		Am	Please ended item 5 per FH 11,	Type or Pri	int in B	lack Ir	ndelible	Ink.	Ensure	All Copie	es Ar	e Legi	ble.		
		•	For State Registrar	State of M	ype or Print in Black Indelible Ink. Ensure All Copies Are Legi 7/2012 Carroll County GC State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20							2	38	403	
	Physicia	ın/	Decedent's Name (First, Middle, Las	t)						2. Date of D Month	eath	ay	Year	3. Time o	
Aye.	Medic Examir	cal	4a. Facility Name (if not institution, give	street and number)	200	1-3	4b. City, Tov	vn, or Lo	ocation of Dea	10	29	c. County of	15	0800	OPM
-	Marie -		Copper Ri	dge			5	414	وصي:			_		_	
16	Funeral Director		5. Social Security Number 6. Security Number 12.63.	7. Ag	7. Age (In yrs. last birthday) M 2 \square F 85 Yrs. If Under 1 Yehr If Under 24 Hrs. 8. Date of E (Month, I have been supported by the last of the							ay, Year) Cour			or Foreign
	nd now at	١	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Location							I	MD I	0d. Inside C	City Limite
	Marytar 18a-fsl tiffied	recto	MD Carroll			ksbur									s 2 X No
	th the l 3a or 2 t be no	Funeral Director	10e. Street and Number	_ 4			10f. Zip Co					itizen of W	hat Cour	itry?	
	eath w	-une	2600 Deer Park Ro	12. Was Decedent	Ever in U.S.	13. \	21048 Was Decedent	of Hispa	anic Origin? (S	Specify Yes or No		USA 14. Race	- Americ	an Indian,	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	<u>م</u>	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Sy Yes 2 No WWII If Yes, Give Year or Dates. Armed Forces? 1 Sy Yes 2 No Specify: Black, White, etc. 1 Yes 2 No Specify: Specify: White									etc.			
15-	72 ho an "nai Medica	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give I	lent's Usual O kind of work d O NOT use rei	one durii	on ing most of wo	orking	16b. l	Kind of Bus	siness/Ind	dustry	
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land	be filed ental H ked ot ic ever	To B	17. Father's Name (First, Middle, Last) Elmer Rush Harvey					18		me (First, Middle Viola		,			
fary	should and M is mar aumat		19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address (St	reet and	l Number or Ri	ural Route Numb	er, City o	r Town, Sta	ate, Zip C	Pode)	
	1 and 2 s of Health item 27 i		Patricia Harvey, 20a. Method of Disposition	wife	20b Plac		beer E		Road,	Finksbu		ocation - 0		wn State	
Baltimore,	permit. Page 1 Department of Important: If is any injury or conce.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	/)	Hau	netery, cren gh 's	natory or other Cemete	r place) ry		2/2012	Lad:	iesbu	rg,		
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licens	MOO.	/	- 1				line Fu Hampstea					
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused	d the death. [A7. 0191 1111							Approxima Interval Be	tween
	Phylician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Alg	heine	<u> </u>	Dix	all					-	Onset and	Death
	Examiner		Sequentially list conditions	h —	a consequen	100 01).									
	nsit	Examiner	Sequentially list conditions, if any, leading to humbolate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a son sequen	es 3f):									
	eath certificate be executed attending physician and for use as the burial-transit	el Exa	that initiated events resulting in death) Last	Due to (or as	a consequen	ice of):								_	
68760	cate be physic s the b	edica		d									\perp		
× 68	h certifi tending or use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth			Ectopic pred	nancv				23d. Date	of delive	ery	
. Box	ne deat / the at ched fo	ysici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of dea	ıth 5□	Other (special	fy)			Ì	Mont	th	Day	Year
P.O.	es that the dea signed by the a I be detached f		Part II. Other significant conditions co	entributing to death b	ut not resulti	ing in the u	nderlying caus	se given	in Part I.	23e. Did	tobacco	use contrib	ute to th	e cause of o	death?
rds	require been sig should I	eted	<u> </u>											ably 4 🗖	
Records,	he law te has l	Completed by		·						perf	opsy ormed?	pr de	ior to cor ath?	sy findings npletion of o	cause of
talF	nysician: The lav iis certificat e has director, page 2	Be	25. Was case referred to medical examiner?	In a facility			2		of Death (Che		2 📑 N	10	Yes	2 L3 N0	
of Vital	Physi r this c aral din	으	1 Yes 2 No	Hospital: 1 Inpati 28a. Date of inju	ent 2 ER	NOutpatien		Other: Injury at		Home 5 Res					
ou o	ending sath. rr: After he fune	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	i, Year)	injury		work?	s 2 \square No	28d. Describe	now injur	ry occurred			
Division	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 25 hours after death this certificate has been signed by the attending physici or the tuneral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be determined	nined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
	Hospit 24 hour Funera stely fill	Medical	(Check 2 Medical Examin		xamination ar	nd/or invest	igation, in my	pinion, d	death occurred	at the time, date	and place	e, and due t	o the cau	se(s) and ma	anner stated.
	To the within 2 To the comple		only one) 3 L Certifying Nurs 29b. Signature and title of certifier	e Practitioner: To the	e best of my k	knowledge,		d at the ti ense nu		olace, and due to		e(s) and ma ite signed (
	&c		1 / pu	n			1	10	L186	2	10	0/3	0 5	012	
	64146		30. Name and address of derson who c	ompleted cause of d	eath (Item 23	Sa) (Type, P	o M		114B	Usilve sj	Cay	Kr	2	le -	21176
П	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	B. 1	backer	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38404 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>2012</u> November Richard Edward Halsey 12:07 a^Mm Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min Hours Director 112-28-8278 1 🛛 M 2 □ F Usual Residence of Decede 76 04/30/1936 New York 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 23281 Hickory Hollow Lane 20619 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Field Service Representative</u> Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard Francis Halsey Kathryn Ann Oberholtzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Marjorie A. Halsey/Wife 23281 Hickory Hollow Lane, California, MD 20619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2012 Shelter Island, NY Shelter Island Cem. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Funeral Service Licens Edward N. Brinsfield. Jr. M00052 22955 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ardiac Ph_sician/ archythmic disease or condition min-he Medical resulting in death) ue to (or as a consequence of) Examiner Due to (or as a consequence of): minutes Securitielly list and liferantifany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? after death.

Director: After this certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes 읻 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital within 24 hours To the Funeral Medical

pme State Registrar

To the h

4/30/36

Richard

completely

29a. Certifier

(Check

29b. Signature and title of certifier

(Month, Day, Year)

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25500 Point Lookers Rd

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lorri Anne Hallock Month 5/2012 645pm ^M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 219-82-0420 **Director** 1 M 2 XX 51 2/26/1961 MD Usual Residence of Decedent 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Deale 1 Yes XX No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 6152 Drum Point RD. 20751 USA permit, Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Pipe Fitter Steam Fitter Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Riddle Nancy Anne Orloski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Riddle father 1158 Cedar Ave. Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/10/12 Glen Burnie, MD Atlantic Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ n 03 VERIS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leaving to infractions cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician Box 68760 USe as attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year treen signed by the a should be detached t Yes 2 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by encephalopat 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has prior to death? perform Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 🖰 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natura 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

P.O. Division of Vital Records, Hospital or Attending 24 hours after death. 24 hours after death. Funeral Director: At

State Registrar DHMH 17 Rev 06-2011

29a. Certifier

29b. Signature and title of certifier

0. 110 31. Date filed (Month, Day, Year

NOV 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) corott

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. edent's Name (First, Middle Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1131 MOUNT DRIVE PASADENA ARUNDEI ANNE 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 214-50-8729 1 XM 2 □ F 64 4/17/1948 MARYLAND 2 should be filed within 72 hours after death with the Maryland th end Mental Hyglene.
27 Is marked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Evanther must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2X No MARYLAND ANNE ARUNDEL **PASADENA** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1131 MOUNT DRIVE 21122 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 1066 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 X Married Black, White, etc. δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates. 1966 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 TRUCK DRIVER TRUCKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Pege 1 end 2 should be fil Depertment of Health end Mental Importent: if item 27 is marked ပ WILLIAM HILD CLARA GODMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA HILD/WIFE 1131 MOUNT DRIVE, PASADENA, MD 21122 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION injury 4 ☐ Donation 5 ☐ Other (Specify) 11/7/2012 STEVENSVILLE, MD CENTER TRIBU 21. Signature of Juneral Service Acenses Address of FacilityLASTING BEIN_& NEWNAM CR any. ANNAPOLIS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or periatory arrest, shock, or heart fallule. List only one cause on each line. Immediate Cause (Final Pnysician Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sicien end buriel-transit Exami or Attending Physicien: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): sate hes been signed by the ettending physicien page 2 should be detached for use es the burle Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate 1 ☐ Yes 2 Ø No Yes 25. Was case referred to predical funeral director, Be 26. Place of Death (Check only one) 1 Tyes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manual of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury s after death. i Director: Aft Accident 1 ☐ Yes 2 ☐ No the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funersi To the Hospitei Medical Le certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 29c. License number daesas nu) 3 Meen

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State

Registrar

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31. Date filed (Month, Day, Year)

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M1) 21117

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKIHANI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month SCOTT 2012 HANNON 1:28 P. M November Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6614 Jacks Ct. Mt. Airy Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 213-84-6461 Director 1 X M 2 D F Yrs. 50 Usual Residence of Decede April 16,1962 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show winjury or other treumatic event, the Medical Evaniner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 😾 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21771 United States 6614 Jacks Court 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 5+ University of MD Baltimore Campus Physicist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sandra Joyce Cortes Edward Hannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Hannon / Father 6614 Jacks Court, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory Inc. 11/3/12Frederick, Maryland. 21. Signature of Funeral Services 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one callse in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 0 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performę 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 (No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 1 Natural injury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Center Westminster MD 2115 Mento M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year 2012 Month 3:40 AM HUMMELL EUGENE HARVEY November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Nursing Itome Itarford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/2/1928 9. Birthplace (State or Foreign Country)
Pennsylvania 6. Sex 1 ★ M 2 □ F 7. Age (In vrs. last birthday) **Funeral** 178-22-4228 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 X No MD. Harford White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Bradenbaugh Road United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: Il Hygiene. other than "natural", 3 X Widowed 4 □ Divorced White WW II Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, item 27 is marked of မ Hummell Carrie Eugene Sauire 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21161 19a. Informant's Name/Relationship (Type, Print) (Son) 2611 Hunter Mill Rd. E. Joseph Hummell White Hall, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov Date 16. permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, Maryland Cremation Signature of Funeral Service Vicenses 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Speet and Death Immediate Cause (Final Vascular Accident Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Eugene Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) tummell bivision of To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Naturai 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) J32 C09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1106 Milliam MD Kenyillala 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 29 Registrar

DHMH 17 Rev 7/2009

		For State Registrar 1. Decedent's Name (First, Mide	Idle I as		arylani		tificate of		2. Date of D	Reg. I		1-2	3840
Physicia Medic		ANTONIA	+	C. 1P	POL	1770)		Month Moven	nber			11: 42A
Examin	er	4a. Facility Name (if not instituti Suburban Hosp		•			4b. City, Town, c	or Location of Dea da	ath		4c. County of Montg		
Funeral Director		5. Social Security Number 579-58-5607	6. Se	ex	e (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		irth Day, Year	913	9. Birthpla Country	nce (State or Foreig Italy
and show	or	Usual Residence of Decedent 10a. State 10b. Coun	ity		10c. City	, Town or Loc	ation		-				d. Inside City Limit
Maryli 28a-f jotified	Director	MD	Mon	itgomery		Poton							1 ☐ Yes 2 🔯 N
ith the 23a or st be r	ral D	10e. Street and Number	0 I 1	na			10f. Zip Code 2085	54		10g. (Citizen of W USA	hat Country	/?
tems tems	Funeral	11. Marital Status	<i>y</i> na	12. Was Decedent B	ver in U.S.	. 13. V	Vas Decedent of H		Specify Yes or No)-	14. Race	- American	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 ☐ Never Married 2 ☐ M 3 🗗 Widowed 4 ☐ Divorce		Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No	1	Yes 2 No		no nican, etc.)		Specilit!	, White, etc n ite).
72 hound the state of the state	Completed	15. Deced (Specify only hig	nest gra	ade completed)		(Give F	ent's Usual Occup tind of work done O NOT use retired)	during most of w	orking	16b.	Kind of Bus	siness Indus	stry
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12 shouk alth and h 27 is ma r trauma		19a. Informant's Name/Relation Josefa Ippolit			ughter		g Address (Street 07 Ordway						•
age 1 and ent of Hernt; If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	on 3 🗆	Removal from State	20b. Pla	ace of Dispos metery, crem	sition (Name of natory or other place aven Cem		Nov. 12,		Location - C	•	
permit. F Departm Importa any inju		21. Signature of Funeral Service			pace					13.11 S 1 1 1	ome Ir	ic.	, MD 2090
Physician/ Medical Examiner		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)		a. ADVA Due to (or as a		. Do not ente	r the mode of dyin	ng, such as cardia	c or respiratory a	arrest,		A	pproximate nterval Between onset and Death
icate be executed g physician and is the burial-the si	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	1	Due to (or as a Due to (or as a d.			To Th	TRIVE					
To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p coappleted filled in by the funeral director, page 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	23c. If yes, outcome of 1 Live Birth of 2 Pregnant at 9 Unknown	2 🔲 Fetal	death 3 🔲	Ectopic pregnanc Other (specify)	ру			23d. Date Mont		ay Year
ires that the signed by d be detact	d by Pł	Part II. Other significant condit	tions co	entributing to death bu	ut not resul	Iting in the ur	derlying cause giv	ven in Part I.					cause of death?
he law requ ite has been age 2 shoul	Completed by	į							24a. Was auto perf 1 Yes	opsy ormed?	pri de:	ere autopsy or to comp ath? Yes 2	findings available letion of cause of
ician: T	Be	25. Was case referred to medica examiner?	190	Hospital:		_	Othe	ace of Death (Che	eck only one)		1		
g Physer this	te: To	1 L Yes 2 No 27. Manner of Death		28a. Date of injur	y 2	R/Outpatient 28b. Time of	28c. Injury	4 ∐ Nursing y at	Home 5 Resi 28d, Describe			(Specify)	-
tendin leath. :or: Aft the fur	Certificate:	1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could	tigation	(Month, Day,		injury		Yes 2 No					
ital or At irs after or ral Direct led in by			mined	28e. Place of Injur building, etc.		ne, farm, stre	et, factory, office		28f. Location (City or To			or Rural Ro	ute Number,
the Hospi nin 24 hou the Funer apleted fil	Medical	(Check 2 Medical	Examir g Nurs	ician: To the best of ner: On the basis of ex Practicities To the b	amination a	and/or investig	gation, in my opinio	on, death occurred	at the time, date	and plac	e, and due to	the cause	
5 P vill		29b. Signature and title of certific	∍r √r	ngs	MD		29c. License	5 7 9	58	29d. D	ate signed (/	Month, Day,	Year)
		30. Name and address of persor Pinky Singh,					nis Lane	, Potoma	ac, MD 2	0854			,
Stati Registra	r	31. Date filed (Month, Day, Year)											
					-	- 34"							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/29/2012 BERNICE VIRGINIA JOHNSON Medical la Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital C4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery october 29, 2017 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Director 214-60-3622 86 1 □ M 2 🕱 F 1/6/1926 ir than "natural", or Items 23a or 28a-f show the Medical Expenieer must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 USA 14040 Berryville Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married 5-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 StWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working

Mail Clerk -Nat. Geographics (Specify only highest grade completed) Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Leola Brewer Henry Robert Jackson chusan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 <u>Emily Denise Johnson/daughter</u> 14040 Berryville Road, Germantown, MD 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State Seneca Church Cem. 11/6/2012 Germantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service License una 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Stroke Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying yath certifice... Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month detached ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signer, page 2 should be Pulmonary Embolism, Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ĒXProbably 4 ☐ Unknown Diabetes Mellitus, Hypertension, Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate hin 24 hours after death.

the Funeral Director After this certifical pletely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 🔀 No 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huashena 31. Date filed (Month, Day, Year)

NOV 06 2012

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 ☐ Yes 2 ☐ No

1 XYes 2 No

MD

17:00 M

State Registrar 18806 Broken Oak Rd, Boycls, MD 2084/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald Jefferson 07:20 AM Medical 10 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death Rejuvenation Assisted Living Silver Spring Montgomery If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign **Director** 262-32-6943 1 💢 M 2 🗆 F 85 09/27/1927 FLUsual Residence of Dece 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13321 Bea Kay Drive 20904 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. ō 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1952-54 1 ☐ Yes 2 X No Specify. Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ US Government Electrical Engineer other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Jefferson Eunice Mitchell and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Emily J. Jefferson/wife 13321 Bea Kay Drive, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o of cemetery, crematory or other place Page 1 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation Ctr of MD 11/01/2012 Hanover, MD 21. Signatur Funeral Service Lic 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ dementi disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar for use as the buri Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by leukemia 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No 2 \square No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Rejuveration AL 2 1 No 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 Yes 2 No ☐ Accident Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Decritifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier P195607 10,31,2012 and address of person who completed cause of death (Item 23a) (Type, Print) 705 Digital Dr., Suite G., Linthicum MD 21090 Feng Xintouna 31. Date filed (Month, Day, Year) State Registrar NOV OR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1/2/2012 Physician/ SYLVESTER JOSEPH JACKSON 4:00 a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. **214-90-5711** Director 49 1 🛛 M 2 🗆 F 1/25/1963 MD Usual Residence of Decedent 10a, State within 72 hours efter death with the Maryland "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery MD 1 🖳 Yes 2 🗌 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #104 20879 USA 9907 Boysenberry Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Divorced Specify: Completed Black Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done (life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 10th Delivery Man Self-Employed Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 Is marked otl 18. Mother's Name (First, Middle, Maiden Surname) Alverta Sewell rank Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberta Mercer/sister 9813 Bethesda Church Rd., #202, Damascus, MD 20872 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cremation Ctr. Of Md 20c. Location - City or Town, State Date permit. Page 1 a Department of I 1 Burial 2 Cremation 3 Removal from State 11/5/2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Snowden Funeral Home f Funeral Se de Licensee . Signature 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Day 2 🗆 No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funerel Director: After this certificate has been signompletely filled in by the funeral director, page 2 should by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and or investigation and or Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAYED 10110

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Alfredo M. Juania 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince "George's Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, Year) July 15,1944 Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Days 217-43-5028 68 Philippines Director 1**X** M 2 \square F July ms 23a or 28a-f show must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George 1 X Yes 2 No Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Main St. items 23a 20706 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ō, þ 1 Never Married 2 Married Yes Yes, Give Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Specify: Asian Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) 5 College (1-4 or 5+) Elementary/Secondary (0-12) Private Accountant nd Mental Hygien marked other th Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Gloria Martinez Aurelio Juania f Health and N Item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mila Juania/ Wife 6121 Main St. Lanham. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11-12-12 Beltsville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pridgen Funeral Service 9013 Annapolis Rd. Lanham, 20706 23a. Part 1, Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ST Elevation disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sudden carde Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a ld be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Abebe, Amare 2511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Abebe Luck State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 30, 2012 Physician/ 17:00 p M Clarence E. Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Suitland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Director 246-62-1932 1 X M 2 □ F Yrs 70 1942 July 31.North Carolina Usual Residence of Decede I Hygiene. other then "natural", or items 23a or 28a-f show vent, the <u>Medical Examiner must be notified at</u> 10c. City, Town or Location 10b Count 10d. Inside City Limits Director 1 X Yes 2 ☐ No Prince George's Maryland | Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5603 Regency Park Court # 3 20746 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc.
African ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 A No Specify If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed Ämerican 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Pentagon Elementary/Secondary (0-12) College (1-4 or 5+) 12th Motor Pool Chauffeur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H James Alexander Johnson Pannie Moody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 it of Health a Suitland, Maryland 5603 Regency Park Court # 3 Betty J. Johnson - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 2012 4 Donation 5 Other (Specify) Heritage Memorial Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. temas M00560 4001 Benning Road NE 20019 Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or conditi resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physicien and for use as the burial-transi that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the el 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No this certificate 1 Yes 2 10 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5.5m State Registrar

Saltimore.

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Pay4, 2012 Carlton B. Johnson $6:50P_{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 577-44-4569 86 Director 1 🔯 M 2 🗆 F 1926 Wash, DC September29 1 and 2 should be filed within 72 hours after death with the Meryland of Health end Mentel Hygiene.
I fem 27 is merked other then "neture!", or items 23e or 28e-f show other treumetic event, the Medical Examiner must be retified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Ŵashington DC 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 58th St. NE #309 20019 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 Domes 2 □ No Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Black 3 Divorced Specify: Year or Dates. 1946 – 47 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Postal Worker Federal Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lois Greenley Leon Johnson 19a. Informant's Name/Relationship (Type, Print)
Mae Helen Johnson/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #309 Washington, DC20019 58th St. NE Baltimore, 20b. Place of Disposition (Name of 20a, Method of Disposition permit. Pege 1 a Department of H Importent: If ite eny injury or otl Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Triangle, VA /14/12 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pridgen Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Sepsis Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The lew requires that the deeth certificate be executed ettending physiclan end for use es the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day signed by the et Id be deteched fo Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Infected Sacral Decubitus Ulcers Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown after death.

Director: After this certificate has been si
I in by the funeral director, page 2 should Severe Malnutrition 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No 1 ☐ Yes 2 ☐xNo 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔀 No |@ 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation To the Hospitel or Atte within 24 hours after der To the Funerel Director completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nujee Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/6/2012 D0063343 350

State Registrar

Irina Ruban 1500 Forest Glen Road Silver Spring, MD20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

31. Oate filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	Type or Pri	nt in E	Black Ir	ndelible Inl	k. Ensure	All Copie	es Are Le	egible.	
		For	State of M	arylan	•	artment of H		Mental Hy	giene	010	00116
		State Registrar			Cer	tificate of L	Death		Reg. No.2	012	38416
Physicia	ın/	Decedent's Name (First, Middle, La	st)					2. Date of D Month		- Year	3. Time of Death
Medic	al	Eddie Juan	7				-	Nóv.	7 Day	2 [°] 0°12	7:30 A M
Examin	er	4a. Facility Name (if not institution, given 13104 Cabin Wo					Spring			nty of Death ntgom	erv
Funeral		5. Social Security Number 6. S		e (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of B	irth	- -	place (State or Foreign
Director			IX M 2□F	97	Yrs.	Months Days	Hours Min.	(Month, D		Coun	
d sow	L	Usual Residence of Decedent 10a, State 10b, County		100 City	, Town or Lo	action		02/20	/ 1915		
arylan a-f sh fied a) 2 2	MD Montgon	nerv	· '		Spring					10d. Inside City Limits 1 X Yes 2 No
he Ma or 28 e noti	Į.	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Inequatment of Health and Mental Hygiene. Inequatment of Health and Mental Hygiene, and inportant if firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	13104 Cabin Wo	ood Drive	<u> </u>		20904	4		USA		,.
death items ier m		11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S		Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No		ace - Americ	
after or ", or xamir	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give	No		Yes 2 X No		o nican, etc.)		lack, White,	
atura cal E	etec	15. Decedent's E	Year or Dates.		16a Decer	lent's Usual Occup	ation				
n 72 h an "n Medi	Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4 or 5		(Give I	kind of work done of NOT use retired)		rking	16b. Kind of	Business/In	oustry
withii glene ler th		5	College (1-4 or 3)+)	Fari	ner			Agric	ultu	re
tal Hy	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Na			ıme)	
uld be I Men narke natic	-	Colon Judd			T		Rebecc	a Chal	mers		
2 sho th and 27 is r		19a. Informant's Name/Relationship (1) Elnora McLean				g Address (Street a			-		
and Heal		20a. Method of Disposition	MICCE	20b. Pl		4 Cabin	wood D	Date	T -	n - City or To	·
age 1 ent of nt: If i		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Ce	metery, cren	natory or other plac S Cha. (30m 11/		Broad	•	
permit. F Departm Importa any inju		21. Signaturé of Funeral Service Licen									cal Home
Ped III		Jam Cely Ch	nexa:1	our	/						4D 20601
		23a. Part 1. Enter the disea. , or com shock, or heart failure. List only of	plications that caused one cause on each line	the death	. Do not ente	r the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition	my	oca	dea	O Infa.	retur				Onset and Death
Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):						
	ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of:						
ted I ansit	Examiner	Cause (Disease or injury		a 00/100qu	3/100 017.						
executed vian and urial-transit		that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):						
te be nysicia he bu	dical		d								
eath certificate be sattending physicis d for use as the bu		IF FEMALE:	00-16	,							
ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	death 3 [Ectopic pregnanc Other (specify)	у			Date of delive	ery Day Year
he de	ıysi	1 Yes 2 No 9 Unknown	9 Unknown	t time or de	eatii 5 L	Other (specify)					,
requires that the der been signed by the s should be detached	y P	Part II. Other significant conditions of	ontributing to death b	ut not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to th	e cause of death?
quires an sign	Completed by	Cardiony po	ith					1 🗆	Yes 2 No	3 🗆 Prob	pably 4 Unknown
law rec has bee	plet		0					24a. Was		o. Were autop	osy findings available repletion of cause of
The la	Som							perf	ormed?	death?	
cian; ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Che				•
Physician: The lav this certificate has aral director, page 2	안	1 Yes 2 No	1 Inpatie		R/Outpatien		4 ☐ Nursing F	lome 5. Res)
After fune fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day		injury	28c. Injury work' M 1 🗆	rat ? Yes 2 □ No	28d. Describe	how injury occi	urred	
or Attenuing Physician: The law requires that the death certificate be iter death. Irector: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 Suicide 6 Could not b	28e. Place of Inju		ne, farm, stre		103 2 110	28f. Location (Street and Nun	nber or Rural	Route Number,
tal or		4 El Horniolde determined	building, etc	. (Specify)				City or To	wn, State)		•
fospit 4 hour unera ely fill	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	sician: To the best of	my knowle	dge, death o	ccurred at the time	, date and place,	and due to the c	ause(s) and ma	inner as state	ed. use(s) and manner stated.
To the Hospital or Attenuing Is within 24 hours, ifter death, To the Funeral Director: After completely filled in by the funer		29b. Signature and title of certifier	He Practitioner to the	best of in	Machiledge	death, obcurred at th	visitime, date and p	lace, and our to	tine course) and	d manner as e	teted:
7 . № 6 .		250. Signature and title of certifier	1 11.			29c. License	_	_	29d. Date sign	ned (Month, L	Jay, Year)
3		30. Name and address of person who	completed cause of di	agth (Itom '	23a) /Time D		3235		1/7/	,, ,	
BU		Darryl H	//	136	35 (type, r)	Balhn	~~	Re	('au	rel
Stat	~ ,	31. Date filed (Month, Day, Year) NOV 0 8 20:	32 Registra	r's Signatu	re	V	-				
Registra	l a	1101 0 0 40	The Land	1 17	1814	Real					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #175tale Bernar Harra 693 Debarre 1017 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month ainio Medical 4a. Facility Name (M-not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LINTHICUM HEIGHTS ANNE ARUNDEL TATE CHESAPEAKE HOSPICE HOUSE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 401-42-9427 1 - M 2 X F 10/15/1915 KENTUCKY 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location Director MARYLAND ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 8407 PIONEER DRIVE 21144 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian.

Year or Dates

College (1-4 or 5+)

Samuel Tilden Jacobs

3. Time of Death

10d. Inside City Limits

Black, White, etc.

Specify: WHITE

LAW ENFORCEMENT

20c. Location - City or Town, State

STEVENSVILLE, MD

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11/5/2012

22. Name and Address of Facility LASTING, TRIBUTES BY FELLOWS

PEARL JACOBS Pearl Salmons

1 Yes 2X No

12:15AM

permit, Page 1 and 2 should be filed with. Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic and ince. Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

à

Completed

Be

မ

1 Never Married 2 Married

15. Decedent's Education

(Specify only highest grade completed)

3 Widowed 4 XDivorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

SAUNDRA KELLY/DAUGHTER

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Euneral Service Licensee

1 Burial 2 Cremation 3 Removal from State

NOV 05 2012

12

SAMUEL SALMON-

20a. Method of Disposition

physiclan and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

	1 Al		BESTGATE ROAD,	ANNAPOLIS,	MD 2140	AL CA	KE					
	23a. 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure sist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):											
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	accedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of de Month										
ted by Pi	Part II. Other significant conditions of	use contribute to										
Comple				24a. Was an autopsy performed?	death?	itopsy findin completion s 2 No	of cause of					
Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Check	only one)	7.47	HOS/-	3/C					
<u>.</u>	1 Yes 2 No	1 Inpatient 2 ER/Outpatient 3		me 5 Residence		ify) H	aus 6					
ficate	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	(Month, Day, Year) inĵury	28c. Injury at work? M 1 Yes 2 No	28d. Describe how inju	ry occurred							
Cert	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
Medical Certificate: To	(Check 2 ∟ Medical Exam	vsician: To the best of my knowledge, death occi niner: On the basis of examination and/or investigat rse Practitioner: To the best of my knowledge, dea	tion, in my opinion, death occurred at	the time, date and place	e, and due to the	cause(s) and	i manner stated					
	29b. Signature and title of certifler	Dentaly	29c/Thense number 38	29d. D	ate signed (Monti)22012					
	MICHAEL J.L	completed cause of death (Item 23a) (Type, Print) 445 A	Definse nnapolis,	Highu MD &	2140	2/					
	31 Date filed (Month Day Vear)	OO Deintage Cincenter										

1 ☐ Yes 2 No

HOUSE KEEPER

CHESAPEAKE CREMATION

20b. Place of Disposition (Name of

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

P.O.BOX 51 GLEN BURNIE, MD 21060

State

Registrar

12-08324 George E. Johnson

Physician/ **Medical Examiner**

> **Funeral** Director

Please Type or Print in Black Indelible	-					
State of Maryland / Department of 1-For State Certificate of Registrar		Hygiene 2 (112 38418			
1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Yea	3. Time of Death			
George Johnson		November 3, 2012	" 2050 hrs			
Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Dea Annapolis	4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel				
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 215-34-6565 1 M 2 F 73 Y	Months Dave Hours Mi		Foreign			
Usual Residence of Decedent						
10c. City, Town or Local Annapol Maryland Anne Arundel Annapol			1 Od. Inside City Limits 1 Yes 2 YNo			
10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	nat Country?			
1185 Madison St. Apt A4	21403	US	A			
	Vas Decedent of Hispanic Origin? (& f Yes, specify Cuban, Mexican, Puerlond Yes 2 \textbf{X} No specify:		14. Race - American Indian, Black, White, etc. Specify: Black			

	215-34-6565 12	X_M 2F		/ 3 Yrs.			Au	g zo	1939	ħΦ	ennyrand	
Usual Residence of Decedent												
	10a. State 10b. County		10c. City, Tow	n or Locati	on						10d. Inside City Limits	
<u></u>	Maryland Anne A	Arundel	Anna	poli	.S						1 Yes 2 XNo	
ಸ್ಥ	10e. Street and Number	•		10f. Zip Code 10g. Citizen							en of What Country?	
	1185 Madison S	St. Apt A	4		2140	3			USA	USA		
Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race White Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race White Yes, Sive Year Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Specify: Specify:								14. Race - White,		ican Indian, Black,	
∓									В	lack		
정	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)									iness/	ndustry	
mplet	Elementary/Secondary (0-12) 9th	+)								Cleaners		
ខ្ញ	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maide								faiden Surname)			
Be	George H. Johr	nson				Est	her Hi	cks				
ပ	19a. Informant's Name/Relationship ((Type, Print)	1	9b. Mailing	Address (Str	eet and Num	ber or Rural Ro	ute Numb	er, City or Town	, State	, Zip Code)	
	Antoine Willia	ams(Nephev	$_{\it I}$) $_{\it I}$	2107	W. Sa:	ratog	a St.	Balt	imore,	M	d. 21223	
	20a. Method of Disposition				tion@Name of	emetery,	Date	- 1	20c, Location - (City or	Town, State	
	1 X Burial 2 Cremation 3	Removal from Stat		rematory of other place) Memorial Park						01	is, Md.	
3	21. Signature of Funeral Service Lice	,		2WMmme aiRedessenfeelitySons Mortuary, P.A								
	Lavy 15, Re	esi		19	22 Fo	rest	Dr. An	napo	lis, M	ſd.		
	23a. Part I. Enter the disease, or com failure. List only one cause on e	each line.				g, such as c	ardiac or respira	tory arres	t, shock, or hear	t	Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease a or condition resulting in death)	Atherosclerotic C		ular Dise	ease						Deali	
	or condition resulting in death)	Due to (or as a consec	quence of):									
×	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	nuence of):								-	
Enter Underlying Course C.												
Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):								1	
	d	1	_									
an/Medical	UNPENDED	AMENDED										
Me	IF FEMALE:	23c. If yes, outcome	e of pregnanc	,					23d. Date of d	elivery	/	
an	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fet	al death 3	Ectopic	pregnancy		Month		Day Year	

Physician Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, MD 21215-0036

To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physicia

Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic alcohol abuse

23e. Did tobacco use contribute to the cause of death? 1 Yes 24a. Was an

2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 1 ✓ Yes 2 No

d b	Chronic alcohol abuse				1 Yes 2 I	No 3 Probably 4 🗸 Unknow		
Completed	-				24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy findings availa prior to completion of cause of death? 1 Yes 2 No		
	25. Was case referred to medical			26.Place of Death (Check	only one)			
To Be	examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3 I	DOA Other Nursi	ng Home 5 Residenc	e 6 Other:		
<u></u>	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury	occurred		
Certification	3 Suicide 6 Could not be determined	28e Place of Injury - At h	ome, farm, street, factor	28f. Location (Street and Number or Rural Route Number, C or Town, State)				

29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only)									
one)	2 Medical Examiner: On the basis of examination and/o	r inyes	stigation, i	n my opinion, death occurred at the time, date a	and place, and due to the cause(s)				
	and manner stated.	$\angle \Delta$							
29b. Şignatu	re and title of certifier		7	29c. License number	29d. Date signed (Month, Day, Year)				

O.C.M.E. November 4, 2012

30. Name and address of person who completed cause of death (Item 23a) 900 W. Bałtimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. Assistant Medical Examiner

31. Date filed (Month, Day, Year) NOV 07 State Registrar

32. Registrar's Signature

ORIGINAL

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lionel D. Kupersmith 2012 Medical November 11:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min. Director 579-58-9795 66 1 X M 2 □ F June 11, 1946 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location Directo 10d. Inside City Limits Maryland Montgomery Germantown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19768 Teakwood Circle 20874 United States 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No 14. Race - American Indian. δ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Community Volunteer Charity traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Department of Health and Ment, Importent: If item 27 is marked any injury or cett. Donald Louis Kupersmith Regina Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clover Hill Circle, Egg Harbor Township, NJ 08234 Ronald J. Kuperman (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date November cemeters crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Temperature 1 Park 2012 Olney, Maryland 21. Signature of Funeral Cervice Licensee 22. Name and Address of Facility DeVol Funeral Home, M00689 <u>10 E</u>. Deer Park Drive, Gaithersburg, MD 20877 23a Part I furter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be report failure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition Medical Due to (or a consequence of): Examiner UMI Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed onaestive that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Day signed by the a Id be detached f Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 canc To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funerel Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I Completed 1 Yes 2 No 3 Probably 4 Unknown D 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Ascites 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No မှ 1 Yes 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation М 3 - Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 41162 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gant 19529 Doctors Drive 2087 Germantown 31. Date filed (Month, Day, Year) 2. Registrar's Sign

DHMH 17 Rev 06-2011

State

Registrar

0 6 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended = State Registrar 20b, rls, tchd, 10/31/12Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/24/2012 HARRY MICHAEL KEENE 11:50 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TALBOT HOSPICE HOUSE EASTON TALBOT Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Min. Birthplace (State or Foreign Country) **Director** 217-26-7442 1 🛛 M 2 🗆 F 12/22/1930 WASHINGTON, DC i and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov items 23a or 28a-f sho 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD TALBOT EASTON 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28256 WIDGEON TERRACE 21601 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner 14. Race - American Indian, Armed Forces?

1 No Yes 2 No ō Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give Specify: WHITE 3 🗌 Widowed 4 🗌 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ENTREPRENEUR INDUSTRIAL SUPPLY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CARLOS JOSEPH KEENE ETHEL BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADA F. KEENE/WIFE 28256 WIDGEON TERRACE EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 $11/17^{\text{Date}} 012$ Department of Important: If i any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) $\frac{30/2012}{}$ HURLOCK, MD Sign of Fundal Service Licenses FENDEN SAND HELLE TO BEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Pnysician/ disease or condition resulting in death) AWTU 0114 Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and I for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the at Id be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an has autopsy within 24 hours after death,

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag performed 1 ☐ Yes 2 ☑ No Yes 2 No or Attending Physician: 25. Was case referred to ical examiner? Be 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HOSPICE Hospital: 1 🗌 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at work? Certificate 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the Dist of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) person who complete cause of death (Item 23a) (Type, Print) LUDWIG J/. EGLSEDER, III, MD 503 CYNWOOD DRIVE, EASTON, MD 21601 RS 11+1VA 31. Date filed (Month, Day) State 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Shirley Ann Knight 2012 Nov. 0 3:30p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 80 Spears Hill Rd. Elkton Ceci] Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 22-38-0436 1 □ M 2🛣 F 60 Yrs. 4/30/1952 PA Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10b. County notified at Director 28a-f 1 Yes 2 X No MD Cecil Elkton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral USA 80 Spears Hill Rd. 21921 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Force Black, White, etc. ö þ 1 Never Married 2X Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates white "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 11 Title Clerk Auto event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of P William K. Turner Dorothy May Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Harry I. Knight/ husband Spears Hill Rd. Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 5 X Burial 2 X Cremation 3 - Removal from State Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Vet Cemetery 11/20/12 22. N R.1 259 21. Signature of Funeral Service Lice Name and Address of Facility T. Foard Funeral Home, P.A. uchand E. Main St. Elkton, MD 21921 23a. Part 1 Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate bause (Final Physician/ Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death detached 1 Yes 2 I the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has perform this certificate ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical

Records, Division of Vital spital or Attending Physhours after death.
neral Director; After this y filled in by the funeral di Hospital 24 hours a To the within 2

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Registrar

29a. Certifier

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ ICHAN MD

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DOO 6 2190 11/12

29d. Date signed (Month, Day, Year)

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Linda Yvonne KERSHNER 14, 2012 November 3:46 p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington 25 West Hillcrest Road Hagerstown Social Security Number 1 Year If Under 24 Hrs. If Under 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, You April 18 1 M 2 X 65 Maryland **Director** 218-74-2974 Usual Residence of Decedent 28a-f show 10b County or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 25 West Hillcrest Road USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 N Divorced Specify: white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) church 11 custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Daniel Lorshbaugh Marie Swain and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is Robert DeBow -brother-in-law 1016 Salem Avenue, Hagerstown, Maryland 21740 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State injury or Important: It any injury or Hagerstown Crematory 11/19/12 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME Mobel (S) 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the ode of dving, such as caudioc or respiratory arrest. Approximate hteryal Between shock, or heart failure. List only one cause each line Immediate Cause (Final WON 7-4 Pnysician/ disease or condition resulting in death) Medical o (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician a Physician/Medical death certificate be Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Į, Month Day Year Pregnant at time of death detached the P.O. signed by t Part II. Other significant conditions contributing to death but not res g in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? မ 2 X No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending Director: A 2 No hours after death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by Homicide City or Town, State) within 24 hours a Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa 29d. Date signed (Month, Day, Year) NON State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of M	aryland	-			and M	ental Hy	giene	9	0 00100	\cap
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	Director		216-22-7923	1 🗆 M 2 🗶 F	85	Yrs.	Months Days	Hours	Min.	(Month, Da 05/20/			Country)	
	nd thow at	or	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation	11	1	03/20/	172	7 110	10d. Inside City Limits	-
	/lanyla 8a-f s tified	Director	 Maryland Washi	ngton	Hage	rstow	n						1 ☐ Yes 2 🏝 No	
	a or 2	Ö	10e. Street and Number	0			10f. Zip Code				10g. C	itizen of What	Country?	_
	th with ms 23 must	Funeral	19532 Lorraine				21742				U.	S.A.		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican 1 Yes 2 No If Yes, Specify Cuban, Mexican 1 Yes 2 No Specify:						jin? (Spec , Puerto F	ify Yes or No- lican, etc.)		14. Race - Ar Black, WI Specify: W	·		
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8760	eath certificate b attending physic d for use as the b	Med	IF FEMALE:	1							-			
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/Ita	Physician: this certificaral director,	To Be	examiner? 1 Yes 2 No	Hospital:	nt 2 ED	1/Outpatient	Othe	ce of Death					· ·	1
0	Attending Physician: rr death. ector: After this certific by the funeral director.		27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of injury	y 28	b. Time of injury	28c. Injury	at		Bd. Describe h		Other (Spe y occurred	ecity)	1
Division of Vital	tendir leath. tor: Af the fu	Certificate;	1 Natural 5 ☐ Pending 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could n	ation of he			M 1 🗆 '	Yes 2 🗆 N	Vo O					
NSIN IN	or At after of Direct	Cert	4 Homicide determine		y - At home (Specify)	e, farm, stree	et, factory, office		28	3f. Location (S City or Town			ural Route Number,	1
	ospital hours Ineral ly fillec	edical		Physician: To the best of n										Ì
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Affer the completely filled in by the funeral promotes the funeral promotes of the funer	Σ	(Check 2 Medical Exonly one) 3 Certifying		amination ar	nd/or investig	gation, in my opinior	n, death occ	urred at th	ne time, date ar	nd place	, and due to the	e cause(s) and manner stated	
_	2 with 2		29b. Signature and title of certifier	Les Aziz			29c. License			2	29d. Dat	te signed (Mor	th, Day, Year)	
	• [-	30. Name and address of person w		ath (ltar= 00	la) (Time C	D6689				11	1711		\dashv
Ji	U+2		Mohammed Aziz,			, , , , ,	,	Media	al C	amnue	Rd.	Hagers	21742 town, MD	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar			a that					00		1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Mark L. Kaminkow October 7:12 p 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1514 Carriage Hill Drive Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 220-42-8114 1 XM 2 F 65 4/1/1947 MD Usual Residence of Deced 10a. State 10c. City. Town or Location 10d. Inside City Limits MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Carriage Hill Drive 21157 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify. white 3 Widowed 4 Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) salesperson Sears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Kaminkow Nellie Irene Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mary Lou Kaminkow, wife 1514 Carriage Hill Drive, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Carroll Cremation 10/31/2012 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 22. Name and Address of Facility Eline Funeral Home Signature of Funeral Service Licensee Lemmer Hampstead, MD 21074 Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to or as a consequence of) que tially liet conditio if any, leading to immediate Due to (or as a consequence of)

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items 23a

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permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ont, any injury or other traumatic event, once.

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Examiner , or

the Medical

Director

Funeral

by

Completed

Be

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72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine burial-tran Physician/Medical Completed by page 2 ours after death.

eral Director: After this certificate I filled in by the funeral director, pag Be မ Certificate:

Medical

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

Johanna DiMento,

NOV U 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

The law requires that the death certificate be executed

or Attending Physician;

To the Hospital within 24 hours a

Division of Vital Records, P.O. Box 68760

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of): d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (Check	
examiner? 1 ☐ Yes 2 MNo	Hospital: Other:	me 5 Residence 6 □ Other (Specify)
27. Manner of De h 1 Natural 5 Pending 2 Accident Investigation	n (Nontri, Day, Year) Injury work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death occurred at the time, date and place, ar	nd due to the cause(s) and manner as stated,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cayse(s) and manner stated.

ated

Day, Year)

signed (Manth

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8

State

Registrar

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s

555 S. Center St., Westminster.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Claire M. Kelly 6:35 PM November Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Inpatient Care Center Harwood Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Director 035-22-3210 1 □ M 2 😾 F May 7, 1933 Usual Residence of Dece Rhode Island and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. The was 23e or 28a-f show other than "natural", or Items 23e or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Anne Arundel 1 Yes 2 X No Edgewater 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Lee Airpark Drive 21037 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. φ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Doire Georgianna Bosclaire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John F. Kelly, Jr.</u> 2439 Alsop Court, Reston, Virginia 20a. Method of Disposition permit, Page 1 a
Department of IImportant: If ite
eny Injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 11-10-12 Clinton, Maryland 21. Signatur Fun II Service Licence 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Fart 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition neumonia Week Medical resulting in death) Examiner Due to or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) erei Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physiclan: The law requires that the death certificate be executed choscolos1 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Tes 25. Was case referred to predical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 6, Amadou Abdullah Kamara 201^{rga} 2243 hrs₩ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Washington Adventist Hospital Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year] 948 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign Days 430-33-5072 Director 1 🛛 M 2 🗆 F Sierra Leone, 64 October 28. <u>West Africa</u> or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Direct **Maryland** Prince Georges Greenbelt 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? West Funeral 20773 7030 Hanover Parkway; Apt. B-2 Sierra Leone, Africa 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Force 6 Black, White, etc. þ within 72 hours after 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** If Yes. Give 3 Widowed 4 Divorced Specify: Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 is and Mental Hygiene.
7 is marked other than "r (Specify only highest grade completed) (Give kind of work durie d life. DO NOT use retired) kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Silver Cab Company Taxi Cab Driver 6 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Abdullai Kamara Fanta Turay and 2 should b Health and Metem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 20008 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fatu Kamara (Daughter) 4411 Connecticut Avenue, N.W.; Apt. 313; Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 17^{10} 2012 injury or 1 A Burial 2 Cremation 3 Removal from State Maryland National Memorial Park 4 Donation 5 Other (Special Laurel, P.G. Co. Maryland 21. Signature of Foneral Servi 22. Name and Address of Facility R. N. Horton Company Morticians, 'n, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition 2 hrs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 <a>Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death 5 Other (specify) Month detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes 2 X N filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔼 No 1 Tes Other: မ 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 06-2011

State

6 SPA

brenbelt, MD 20770

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** EVELYN LUCILLE KNISLEY 10:45 a. 2012 Nov. 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westernport

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | 1 Moran Manor Nursing Home Allegany Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2▼F Yrs. 84 Director 425-42-5045 13,1928 Collins, MS Usual Residence of Decedent a or 28a-f show the notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Rawlings 10f. Zip Code Allegany MD 10g. Citizen of What Country? 10e, Street and Number with "natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examinar once. 23668 McMullen Highway, S.W. Funeral 21557 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: 3 √ Widowed 4 □ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Thrift Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Benjamin Knight P Maggie Pearl Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Billhimer/Personal Rep. 23668 Mcruute

20b. Place of Disposition (Name of cemetery, crematory or other place) 23668 McMullen Highway, S.W. Rawlings, MD 21557 20c. Location - City or Town, State 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 11/14/12 Rockville, MD 21. Signature of Europeal Service License 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final On serse pertensive Kenl **Physician** disease or condition resulting in death) /Medical Due to ar as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the ad be detached to 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Q Q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1□ Yes 2121No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician: To the Hospital or . within 24 hours after To the Funeral Dir

Medical

State Registrar 29b. Signature and title of certifier

Jesus Tan, M.D. 4 Broadway 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

21532

Frostburg, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene														
							rtificate of Death					Reg. No.20 2 38428				
	Physicia	in/	1. Decedent's Name (First, Middle, Last)					2. Date of D Month				Day Year 12.40				
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	EXAIIII	iei	5300 Baltimore A	,				City, Town, or Location of Death Chevy Chase				4c. County of Death Montgomery				
4.00	Funeral		5. Social Security Number 6. Sex		e (In yrs. la	ast birthday)		r 1 Year	If Under 2		8. Date of Bir		Mont	9. Birthr	olace (State	e or Foreign
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	o filed within 72 hours after death with the Maryland tall tyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	I Director	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation		<u></u>		Aug. 1	4,	1912	$\overline{}$		City Limits
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			10e. Street and Number 10f. Zip Code								10g. C	itizen of W	hat Cour	itry?		
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		Completed by Fu		2. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔼	ver in U.S	3. 13. V	Vas Deced	dent of His	spanic Origin, Mexican,	n? (Spe Puerto	cify Yes or No- Rican, etc.)		14. Race	- Americ , White, e		
36	al", o		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐ Yes 2 ☑ If Yes, Give Year or Dates.	No	1	☐ Yes	2 🔀 No	Specify:				Specify:			
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21	ed within Hyglene. other thai	To Be C	8			Hor	nemak	er					Own H	ome		
and	ntal Hy ed oth		17. Father's Name (First, Middle, Last)								e (First, Middle,	Maiden	Surname)			
Ž	permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other treumatic eve once.		Patrick Laverty 19a. Informant's Name/Relationship (Type	Print)		10b Mailin	^ - -	(Chrant a			organ I Route Numbe	on City o	- T C4	4- 7:- 6)	
Š			Mary Marron/Daug	•		530	0 Ba	Ltimo	re Av	e. (Chevy C	hase	Md ,	. 20	815	
Baltimore, Maryland			20a. Method of Disposition			lace of Dispo			0)		Date	20c. l	ocation - 0	City or To	wn, State	
Ë			1 🖾 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1 Gat	emetery, cren te of emeter	Heave	n n	N N	ov. 201	2 ¹² ,	Si	lver	Spri	ng. N	1d.
3alt			21. Signature of Funeral Service Licensee	() мо	0215	22	. Name ar	nd Addres	s of Facility	DeV	7o1 Fun					
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	Medical Examination and the burial transit the buri		disease or condition resulting in death) Debility Due to (or as a consequence of):													
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		iner	b. Bequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):													
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89	certifi	M/M	ZOD. Was decedent pregnant	c. If yes, outcome of	of pregna	ncy] ::_						23d. Date	of delive	ery	
XOB The part of the part												Mon	Month Day Year			
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<u>E</u>	an: Th tificat tor, pa	BeC	Cerebrovascular 25. Was case referred to medical	Accident				26. Pla	ace of Death	(Check	1 Yes	2 🔯 N	lo 1	Yes	2 ∐ No	+
Zi:	nysici lis cer I direc	일	examiner? 1 ☐ Yes 2 🖾 No	Hospital: Other:					sing Ho	g Home 5 ☒ Residence 6 ☐ Other (Specify)						
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	ospita hours ineral ly fille		29a. Certifier 1 X Certifying Physici	an: To the best of r	ny knowle	edge, death o	occurred a	t the time	, date and p	lace, ar	nd due to the ca	ause(s) a	and manne	r as state	ed.	
	the Hi nin 24 the Fi nplete	Mec	(Check 2 Medical Examine only one) 3 Certifying Nurse I	r: On the basis of ex Practitioner: To the	amination best of m	and/or invest ny knowledge,	igation, in death occ	my opinio urred at th	n, death occi ne time, date	urred at and pla	the time, date a ce, and due to t	ind place the caus	e, and due t e(s) and ma	o the cau	use(s) and r tated.	nanner stated.
	5 1 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29b. Signature and title of certifier Jolelyne Koudtchou, mi) 29c. License number D63748 29d. Date signed (Month,								Month, E	Day, Year)					
	10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)														
			30. Name and address of person who corr Jocelyne Kouatch				,	1 Ros	ad Sui	lte	600. Ca	alve	rton.	Md.	207	05
	Sta		31. Date filed (Month, Day, Year)	32 Registra	r's Signat	ure -					., 50		,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Frank Edward Laddbush, Jr. 2012 4:45 рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 102 University Blvd. East Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Min 577-62-5672 Director 1 X M 2 □ F 65 Nov. 25, 1946 Washington, DC Usual Residence of Deceder or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinar must be notified. 10a. State 10c. City. Town or Location Director MD Montgomery 1 🗌 Yes 2 🖾 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 University Blvd. East 20901 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2 ₺ No Specify: If Yes, Give Year or Dates.Vietnam 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Edward Laddbush, Sr. Mary Elizabeth Malloy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila M. Laddbush/Wife 102 University Blvd. East, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1¾☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 9 2012 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W,. Silver Spring. MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ unce disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day ed by the a Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ å been signated by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \) Residence \(6 \text{ \text{\text{Other}}} \) Other (Specify) 2 No 1 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

I to the Funeral Director: After completely filled in by the fur work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1541 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Pishvaian, MD 18109 Prince P 18109 Prince Philip Drive, Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

NOV 07 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER Day 2 710 M 202 MAJEL S. LENCE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ASTON MEMORIAL 80 -HOSPITAL TON IAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 481-16-2127 1 🗌 M 2 🕱 F 90 12/20/1921 IOWA permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Importent: If item 27 is marked other than "natural", or itema 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD TALBOT **EASTON** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 USA 7598 LONG MOUNT Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Yes 2 No 1 Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highe st grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DISTRIBUTION CLERK U.S. POSTAL SYSTEM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ LOTTIE BLACK L. RAY STEPHENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26974 SHORE HWY DENTON, MD 21629 BEVERLY COLLINS/EXECUTOR Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) JONESBORO CEMETERY 11/15/2012 JONESBORO, IL 21. Signature of Funeral Service License 2FEDEONS dreHEEFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 BHN MERCE ROM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition nora Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the deeth certificate be executed attending physicien end for use es the buriel-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 No tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by amameno 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 1 → Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be To the Hospitel or Atte within 24 hours after de To the Funeral Directo completely filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Cify or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 3/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2160

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NUV

K

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Amended 19b**1-** State Registrar TCHD, 10/31/2012, TLS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct Month 2012 BETTY JANE LEDNUM 28 4:45P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare-The Pines Talbot Easton **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Hours **Director** 0871871921 220-32-2233 BOZMAN, MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1 X Yes 2 No MD TALBOT **BOZMAN** 10e. Street and Number ö 10f, Zip Code 10g. Citizen of What Country? Funeral 23a 23279 SWANN COVE RD. 21612 USA permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items amy injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Waryland 21215-0036 1 ☐ Yes 2 🛣 No 3 XWidowed 4 Divorced Completed Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) -0-HOMEMAKER PRIVATE RESIDENCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM ELMER HARRISON BERTHA MAE MCQUAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA L. HADDAWAY/DAUGHTER 7899 BOZMAN NEAVITT RD. EASTON, MD 21601BOZMAN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place RK 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL 4 Donation 5 Other (Specify) 11/2/2012 EASTON, MD 21. Sign of of FELDOWSADDELFEINBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Adult Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 4 WKS nvonic Securentially but every by the Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Certificate: To Be Completed by Physician/Medical Box 68760 the attending IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year signed by the a P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? Heart 24a. Was an has autopsy performed? Yes 2 Who within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Aursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined

TUS

State Registrar

Medical

29a Certifier

(Check only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Dby, Year)

OCT 31 2012

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Maryl Registrar		tificate of E			eg. No2 0 2	38432		
Physicia Medi			1. Decedent's Name (First, Middle, Last) Elizabeth M.	Le	ednum		2. Date of Death Month	Day Year 2012	3. Time of Death 12:17A M		
Exami			4a. Facility Name (if not institution, give street and number) Talbot Hospice House		4b. City, Town, or East	Location of Death		4c. County of Death Talbot			
i.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In y 220-26-9050 1 \(\triangle M \) 2 \(\frac{1}{3} \) 87	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/30/	9. Bi	rthplace (State or Foreign buntry) MD •		
	'age 1 and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show yor other traumatic event, the Medical Examiner must be notified at	tor		. City, Town or Loc					10d. Inside City Limits		
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Maryland 21215-0036		ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	l 1f	f Yes, specify Cubal	n, Mexican, Puerto I	Rican, etc.)	Black, Whi	te, etc.		
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, M a			19a. Informant's Name/Relationship (Type, Print) Margaret Isman/ Daughter			Tilghma		City or Town, State, Z 21671	ip Code)		
Baltimore,			1 During 2 Compation 2 Pamoual from State	Db. Place of Disposicemetery, crem Mission	natory or other plac	ry 11–8		20c. Location - City o Tilghman			
Balti	permit. Page 1 Department of Important: If i any injury or o	İ	21. Signature of Funeral Service Licensee Sosoph M. Datizowsk C.f.	1240-	umleyAd&s	s Ostrows	ki Fun	eral Homels, MD.			
j	nysiciad Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
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Box 68		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of prediction of the pregnant at time 9 ☐ Unknown	23d. Date of do Month	elivery Day Year						
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		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or prestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
			29b. Signature and title of certifier		29c. License	9887	2	9d. Date signed (Mon	th, Day, Year)		
٥	256		30. Name and address of person who completed cause of death (221 Tea	al Dr. S	Sute. 30	2 East	on, MD. 2	21601		
10	Sta Registr	te ar	31. Date filed (Month Pan Year) 1 2012 32. Registrar's Si	ignature	bare		-				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin	er			nEDI (AZ	C=			ZSTO Wr			c. County of D	GTON COUNTY
Funeral		5. Social Security N				ast birthday)	If Under 1 Year Months Days		8. Date of Bi	irth	9.	Birthplace (State or Foreign
Director		218-50-2 Usual Residence		1 □ M 2 A F	66	Yrs.	Month's Days	Hours Min.	July 3	31, rear	1946 M	Country) [aryland
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ath w	Funeral	12309 11. Marital Status	KICHWOOG	12. Was Decedent	Ever in U.S	S. 13. W		+U Iispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	-	U.S.A.	merican Indian,
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permit. I Departn Importa any inju once,		21. Signature of Fu		nee))	P			ess of Facility Re				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth C. Lee 12:00 p^M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Golden Living Center Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min. 185-10-5445 Director 1 🗆 M 2 🗙 F 102 Oct 1, 1910 Pennsylvania or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Westminster Maryland Carroll 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21158 1190 Stone Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 - Widowed 4 Divorced Specify: Completed white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4 or 5+) Adjuster Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Barnes ဂ္ Charles Curlis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Peabody, daughter 1190 Stone Road, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter) Oblitatory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carroll Crematory 11/2/2012 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis St, Westminster, MD 21157 Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Vea Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury signed by the attending physician end deteched for use as the burial-transit Hospitell or Attonuing Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Atton.Ing Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filler in by the funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 XNo ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R069707 02 2012

State Registrar CRNP 688C POOLS ROAD WESTHINSTER

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

S. FARAMA

LINE

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	State Registrar 1. Decedent's Name	o (First Middle)	/ set)		Ce	rtificate of	Death	1	Reg. No	20	12	3843
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rect	MD	Char	les		La Pla	ta						1 🗆 Yes 2 🔀
Funeral Director	10e. Street and Nun	nber				10f. Zip Code			10g. Ci	itizen of V	What Cour	ntry?
<u>i</u>	6890 Ha	awkins (Gate Road			20646				USA		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20% Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2328 Westport Lane Crofton Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 236-38-2890 89 Director 1 □ M 2 🖔 F 2/18/1923 Georgia ms 23a or 28a-f show must be notified at 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Randallstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3827 Terka Circle 21133 USA 12. Was Decedent Ever in U.S. Armed Forceo?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 X Widowed 4 ☐ Divorced Black. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Curtis Tomlin Ardella Cobb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Siobhan K. Madison/ Granddaughter 2328 Westport Lane, Crofton, Maryland 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. Date 1 Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shiloh Cemetery 11/7/12 Blackshear, GA 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Performs after death.
Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗆 No 1 Tes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ၉ 1 ☐ Yes 2 ₵ No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred HOME 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0052089 Ruth Gallatin, GAMBRILL pleted cause of death (Item 23a) (Type, Print) M.D

Registrar
DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 9,8,17, per fh, g933 11-29-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of De 2 Date of Death Month 11 Physician/ MESSICK, JR. Day 5 SAMUEL Year CARROLL 20:33 M 2.0.1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 104 E. STATE STREET DELMAR WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Min Director 221-24-0920 1 [XM 2 □ F 74 Yrs MILFORD DE Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director SUSSEX DAGSBORO 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 CLOGG DRIVE EAST 19939 USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Maryland 21215-0036 filed within 72 hours after al Hygiene. If Yes, Give Year or Dates WHITE 1 ☐ Yes 2 X No Specify. 3 Divorced Specify: Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 and 2000. PAINTER POULTRY PLANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SR. SAMUEL CARROLL MESSICK, JR. ANN MARIE (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE MESSICK 119 CLOGG DR. EAST., DAGSBORO, DE 19939 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
FIRST STATE CREM.CTR. 11/6/2012 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State MILLSBORO, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SHORT FUNERAL SERVICES 40 local Dhot 609 E. MARKET ST., GEORGETOWN, DE 19947 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) 6202111 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated appets Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been significate has been significated funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Il Director: A ed in by the fr 1 Yes 2 No Investigation 3 Suicide
4 Homicide within 24 hours after dec To the Funeral Directon completely filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of cartil 29d. Date signed (Month, Day, Year) W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ms DAW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State Registrar 6

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edward Lee Manear OVEMBER 3 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Doctors Community Hospital Lanham Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) **Director** 236-66-3946 1 🕱 M 2 ☐ F 69 07-16-1943 Maryland Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Landover 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Z1215-0036

Learnit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "" any injury or other traumater.

Once. 7525 Rouse Ave. 20785 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No UNK

If Yes, Give þ 1 X Never Married 2 Married 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Deputy Director Maritime Commission Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Car1 Edward Manear Caroline Tobias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline T. Manear--Mother 99 Ruritan Drive, Emporia, VA 23847 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 X Removal from State 1st Christian Cem. 4 Donation 5 Other (Specify) 11/6/2012 Emporia, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Park Avenue Thibadeau Mortuary Svc. M01113 Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): AUROUS **Examiner** METHICIALINE RESISTANT STAPH INFECTION Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying tending physician and of for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ periphene Vascular disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed poly Microbial lower exterenty wound intection 24a. Was an Were autopsy findings available prior to completion of cause of ate has bage 2 s death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: မှ within 24 hours after deau.

To the Funeral Director: After this of the funeral director is formulately filled in by the funeral director. 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number

Registrar

State

M.O.

32 Registrar's Signature

043446

12150 Anapolis Load Sut 200 Glendle MO 20769

11.4.12

Rate Fahr M.D.

ROINTAN FARAHI-FAR

NOV 08 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 38440 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov.3. 2012 Pau1 Montalbano 5:25 P J. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 28, 1909 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 078-07-8519 Director 1 💢 M 2 🗆 F 103 Italy permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Potomac 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10212 Democracy Lane 20854 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Hair Stylist Beauty Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Charles Montalbano Josephine Stravalle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles V. Montalbano/Son 8009 Hackamore Dr., Potomac, Md. 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) Nov.8,2012 Silver Spring, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home M00215 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Failure to thrive Medical Due to (or as a consequence of) Examiner Pulmonary fibrosis Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ending physicien and or use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Day signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2K No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 62 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No. within 24 hours after death.

To the Funeral Director. At completely filled in by the form Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 Nov.4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, MD 6001 Muncaster Mill Road, Rockville, Md. 20855 31. Date filed (Month, Day, Year) NOV 07 Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

VOID

CERTIFICATE

2012-38441

SEE

CERTIFICATE

2012-36819

Shariel McClitchen

Completed 1-4-2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth / 01/2012 10:20 P M CAROLYN MUCEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CANDLELIGHT COVE EASTON TALBOT . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) Funeral Hours Min (Month, Day, Year) 96 Director 176-05-4016 1 □ M 2 🕱 F Vrs 03/01/1916 PENNSYLVANIA Usual Residence of Decedent ir than "natural", or Items 23a or 28e-f show the Medical Examiner roust be rectified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland MD TALBOT **EASTON** 1 X Yes 2 No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 W. EARLE AVE. 21601 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married ۾ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 -0-HOMEMAKER PRIVATE RESIDENCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F is marked of ည DOMENIC CASTRACANE ROSE DIPAOLO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 and 2 st Department of Health as Important: If item 27 is eny Injury or other treu LESLYE M. MOSIER/DAUGHTER 900 RIVERVIEW TERRACE ST. MICHAELS, MD 21663 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of QUITEN), OF nath FAVIEN lace) 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 11/10/2012 MCMURRAY, PA 21. Signature of Funeral Service Licensee FELLOWS Addreckenbein & Newnam Funeral Home, P.A. 200 S. HARRISON STREET EASTON, MD 21601 JOHN R. MERCE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CMOW Medical Due to (or as a consequence of): Examiner Janic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō 5 Other (specify) Month Day Pregnant at time of death 9 Unknown n signed by th. 1 be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, cate has been sig ; page 2 should b 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \(\mathbb{A} \) Other (Specify) ASSISTED LIVING in 24 hours aren commented filled in by the funeral direction. ည 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R126198 11/2

Registrar

State

RS 6

ause of death (Item 23a) (Type, Print)
o + (CIW, CAN) - 8579 Com merce Du. # 106 Each, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

32. Registrar's Signature

elear

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 4:06 P_M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O とき 29 2012 Year Layfield Macer en Medical 4a. Facility Name (if not institution, five street and number) Genesis HealthCare-The Pines 4b. City Town, or Location of Death Easton **Examiner** 4c. Tall both Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **M**M 2 □ F 222-20-8213 Months Days Hours Min. 08-28-1935 77 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits Director notified 28a-f Md. Dorchester 1 🗌 Yes 2 🎝 No East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r must be r Funeral 5650 Thompson town Road 21631 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Macer Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Line worker Perdue Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever 2 William Robinson Ida Mae Macer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $21\overline{631}$ 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other traignee. Peggy Macer / wife 5650 Thompson town Rd East New Market, Md Glen Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-04-12 East New Market, Md. Thompson town Cem. Uneral Service Ligensee 22. Name and Address of Facility Bennie Smith Funeral Home Signature 516 S. Main St., Hurlock, Md. 21643 23a. Part 1. Ent. the diseas or come cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive disease or condition Medical resulting in death) Examiner Arten Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Indstage -transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 4 Pregnant 9 Unknown in the past 12 months? Month Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Diabetes, CVA, MI, Anemia 1 Yes 2 No 3 Probably 4 Donknown hyperlipidemia, PVD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 W Yes 2 146 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Records, P.O. Box 68760 Division of Vital To the Hospital or Attending Pleatin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral

State

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

> Shriba FNP-BC

DURAL

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

2012

FNP-BC

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Werdical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

F162359

610 Dutchmans Ln, Easton MD 2160

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 Î 2 12:45 AM Otis R. Macomber, Jr. November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 49 Bonnie Shore Road E1kton Ceci1 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1**X**XM 2 □ F Months Days Hours May 19, 1929 234-46-6724 Massachusetts Director 83 Usual Residence of Decedent 28a-f show 10a. State 10h Counts aţ 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Tes 2 XXNo Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a with Funeral 49 Bonnie Shore Road Medical Examiner must 21921 United States items; within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Xyes 2 No US Army Black White etc 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates. 1950-56 Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) United States Elementary/Seconday (0-12) 12 College (1-4 or 5+) the Training Specialist Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Otis R. Macomber, Sr. Jennie Eve Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Macomber / Wife Bonnie Shore Road, Elkton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Ngvember 13, 2012 1 X Burial 2 Cremation 3 Removal from State Harford Memorial Aberdeen, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Crouch Funeral Home, P.A. Signature of Funeral Service 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ LOSTRIDIUM disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burial Physician/Medical requires that the death certificate be Box 68760 phy as attending IE EEMALE for use 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the a q 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 No page certificate 2 X No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: A М Accident Investigation the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 67466 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cornelius Ope, MD, 14 Rogers Road, Suite 211, North East, Maryland 10+IVA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38445 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ruth Margaret Moyer 5:50 November Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Encore at Turf Valley Ellicott City Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 1 🗆 M 2 🛣 F 068-03-4810 Yrs. 94 10/21/1918 NY Hygiene. other than "natural", or items 23e or 28a-f show ent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct MD Howard 1 Yes 2 X No Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9745 Gudel Drive 21042 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No Specify. 3X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>School</u> Secretary School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Chester Eldridge Edith Elvira Oliver and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health item 27 i Glenda Moyer Milner - daughter 9745 Gudel Drive Ellicott City, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1.2 Department of P Importent: If its eny injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery 11/17/2012 Whitney Point, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Homas uanita 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part . Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Dementia ease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami for use es the burlal-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical JE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? 1 ☐ Yes 2 🔁 No ours after death. eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🖾 No Other: 1 🗌 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Living Hospital or Attending 1 X Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) w D 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Andrew Lazras,

31. Date filed (Month.

MD

3

Maryland 21215-0036

68760

Records,

Division of Vital

Columbia, MD

21044

6334 Cedar Lane #103

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7 Physician/ Month Stacy Meredith McGhee 2012 05:30AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 17501 Bowie Mill Road Montgomery Derwood If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 216-06-1231 Director 42 July 24 1970 New Jersey Usual Residence of Decedent 28a-f show 10b. County items 23a or 28a-f sho ler must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Olney 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Roseneath Court 20832 United States death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black White, etc. ò 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☑ No Specify White "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Accounts Manager Insurance Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Goff Meredith Boyd Susan Dee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 William P. McGhee/Husband 5 Roseneath Court, Olney, Maryland Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crem. 11/08/12 Alexandria, Virginia 4 Donation 5 7 Other (Specify f Fundal Se 22. Name and Address of Facility Barber Funeral Home P.O. Box 5038, Laytonsville, 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Retween Onset and Death Immediate Cause (Final Physician/ Anal Canal Squamous Cell Cancer disease or condition Year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami and -trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months? Dav Year Pregnant at time of death 2 X No the 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available Jas prior to completion of cause of death? autops, performed? 2 2 No page certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Mother's Home 2 🖾 No Other: 1 🗌 Yes After this c ျှ 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) in 24 hours after deau...
he Funeral Director: Aft 1 🛛 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hor To the Fune completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi Tran MA D 0061083 November 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Paul Thambi,

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

9707 Medical Center Dr., #300, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26 per verbal 12/5/12 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u>2012</u> Stephen Martin Morris, II РМ November :48 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10929 Roessmer Ave. Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 214-19-4261 Months Days Hours Jan. 6, 1985 27 Director Maryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Frederick 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1100 Wilson Lane 21701 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 X Never Married 2 - Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Stephen M. Morris Kimberly K. Cargile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen M. Morris-father 13524 Wisteria Dr. Germantown, MD 20974 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Smithsburg Crematory 11/19/2012 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home e of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ an Con 110 disease or condition mon Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a Part II. **Other significant conditions** contributing to death but not resulting in the underlyin*g* cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 24 hours after death.

Funeral Director: After this certificate heleted filled in by the funeral director, pag. 1 🗆 Yes 2 XN 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? mother's home 2 XVo Other: Certificate: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No ☐ Accident☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 🗌 within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21798 000 10 oppermine Woodsboro 31. Date filed (Mon gistrar's Signatur 32. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia	an/	1. Decedent's Name (First, Middle, Last)		-		2. Date of Deat	:h	Year	3. Time of Death		
Medi Exami	cal	CARRIE MAE DAVIS MERRITT 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I	Location of Death	NOVEMBE	ER 7, 2	2012 of Death	1:36 P M		
rd.		RESIDENCE. 10401 CRESCENT P		WALDORF	•	(8)	CHAI	RLES			
Funeral Director			e (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Country			
nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	eation		JULY 2,	1925	ALAB 100	d. Inside City Limits		
Marylar 28a-f sl otified	recto	MARYLAND CHARLES	WALDORF						1 Yes 2 X No		
death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Number 10401 CRESCENT PARK WAY		10f. Zip Code 20601			I0g. Citizen of V				
ire, Miaryland ZIZI3-UU30 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Endmed Forces? 1 Yes 2 In Yes, 1 Yes, 2 Yes Year or Dates.	No If	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 X No	, Mexican, Puerto I	cify Yes <i>o</i> r No- Rican, etc.)	Blac	e - Americar ck, White, etc	C.		
/ I / I D-U	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-12) College (1-4 or 5-12)	(Give k	ent's Usual Occupation of work done du O NOT use retired) SEKEEPER	tion uring most of workir	ng	16b. Kind of Bi		stry		
AIGENTIAND Should be filed we and Mental Hygin is marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last) GEORGE AKINS, SR.			18. Mother's Name		Malden Surname				
e, Mary and 2 should Health and M tem 27 is ma other trauma		19a. Informant's Name/Relationship (Type, Print) PHYLLIS A. SANDERS / DAUGHT	ו סיבוי	g Address (Street ar			-				
baltimore, bernit. Page 1 and bepartment of Hee mportant: If item any injury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem	atory or other place) !	I	20c. Location -	•			
DaltIMOr permit. Page 1 Department of Important: If it any injury or o		21. Stringture of Funeral Service Licensee LYDIA C. THORNION JOHNSON MOOSE	1111 83 PE	ORNION FUNE RNEL JONES	RAL HOME, E & SONS FUNE	A., INDI RAL HOME,	AN HEAD. CLEVELA	MD 206 ND, OHI	40 FOR 0 44103		
- Physician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	the death. Do not enter	r the mode of dying.	/	r respiratory arre	st,	1 1	Approximate nterval Between Onset and Death		
Medical Examiner		resulting in death)	conse dence of):								
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r ou cate be executed physician and the burial-transit	edical Ex	resulting in death) Last Due to (or as a d	consequence of):								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown 23c. If yes, outcome of the pregnant at the pregnant	2 🗌 Fetal death 3 🔲	Ectopic pregnancy Other (specify)	,			te of delivery	/ lay Year		
Jo, F.C. Jires that the signed by all be detar	by	Part II. Other significant conditions contributing to death bu	ut not resulting in the ur	nderlying cause give	en in Part I.				cause of death?		
he law requires the law sequires the has been signage 2 should b	Completed					24a. Was ar autops perform	ne <u>d</u> ?	Were autops prior to comp death?	y findings available pletion of cause of		
cian: T	Be	25. Was case referred to medical examiner?			ce of Death (Check		Z LA NO	100 2			
g Physi g Physi er this c	e: To	27. Manner of Death 1 Inpatie 28a. Date of injury	ent 2 ER/Outpatient y 28b. Time of	28c. Injury	at Nursing Hor	me 5 X Reside					
Attending death. ctor: Affe	Certificate:	1 X Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Year) injury	M 1 □ Y	∕es 2 □ No						
ital or At urs after d ral Direct		4 Homicide determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, stree . <i>(Specify)</i>	et, factory, office		28f. Location (Str City or Town		er or Rural R	oute Number,		
the Hosp hin 24 hou the Fune mpletely fi	Medical	29a. Certifier (Check 2 Medical Examiner On the basis of ex only one) 3 Certifying Nurse Practitioner: To the	amination and/or investig	gation, in my opinion death occurred at the	e time, date and pla	the time, date and ce, and due to the	d place, and due e cause(s) and n	to the cause nanner as sta	e(s) and manner stated. ited.		
N Wiff		29b. Signature and title of certifier Will A Gunu	un	29c. License 1	number		_	e signed (Month, Day, Year)			
60		30. Name and address of person who completed cause of de WILLIAM P. TANNER, M.D. 11	eath (Item 23a) (Type, Pr) CIITTE	101 FOI	от паси	T NICTION	N. MID 20744		
Sta	ite	31. Date filed (Month, Day, Year) 31. Registrar		Ked KOAL	7, 5011E	101, FUI	NI WASH	TNGTOR	N. MD 20/44		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAGNESS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death EJOHNS + tOPKINS HOSPITAL TIMORE 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 215-48-4077 65 Country) Director 1 □ M 2 🏝 F 4/4/1947 PA 10b. County 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 10d. Inside City Limits 1 Yes 2 No |Anne Arundel Lothian 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5221 Cottonwood Dr 20711 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed If Yes, Give Year or Dates Specify:White 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene, College (1-4 or 5+) Elementary/Secondary (0-12) the VP Finançe <u>Financial Planner</u> Be 27 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ၉ Paul H. Barben Doris Rehmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Samantha L. Blankenship Health 40 East Myrtle St Littlestown PA 17340 20a, Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place)
Carroll Crematic 1 Burial 2 XCremation 3 Removal from State 11/2/2012 Cremation 4 Donation 5 Other (Specify) Hampstead MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Little's FH 34 Maple Littlestown PA17340 23a. Part 1. Enter the disease, or complications that caused used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Pulmonery Medical Due to (or as a consumence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the bunal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year certificate has been signed by the a lirector, page 2 should be detached in 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 1 No 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifical letely filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier RES 000 NOVEMBER 1 2012 15410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORLEANS STREET BALTIMORE MD 21287 500 1800 State 3. Registrar's Sig Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lois Ruth Morris November 8, 2012 4:10 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Nursing Center St. Mary's Leonardtown Social Security Numbe 7. Age (In yrs. last birthday) r 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 219-12-3162 1 🗆 M 2 🏝 F Director 89 Yrs. 08/7/1923 **Maryland** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland St. Mary's Avenue 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be by Funeral 20609 23263 Coltons Point Road an "natural", or items Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. White "natural" Completed 3X Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. event, the **U.S.** Government Purchasing Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Department of Health and Men Important: If item 27 is marke any injury or other traumatic Catherine Dove Russell William Lee Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Jackson/ Niece 38877 Morris Point Road Abell, MD 20606 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 11/13/2012 Sacred Heart Bushwood, MD Sun tur o Funeral Service Name and Address of Facility
Mattingley—Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Dise to forms a numerousine of cause. Enter Underlying Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy e Hospital or Attending Physician: The I 24 hours after death.

P. Funeral Director: After this certificate heletely filled in by the funeral director, page perform Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of De th 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 4 14285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

RMR

William D. Boyd, II, M.D.

Registrar's Signatur

25365 Point Lookout Rd., Leonardtown, MD 20650

Ame	end #1	1 per PHY Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. alth Pept. 11-13-12 State of Maryland / Department of Health and Mental Hygiene															
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98	fter d ", or if amine	2		ied 2 X Mamied	Armed Forces? 1 🔀 Yes 2 🗌 If Yes, Give	No				n, Mexican Specify:	, Puerto F	Rican, etc.)		Black,	White, 6		
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<u>E</u>	Page 1 ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2012 Crownsville, MD														
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODCE.		21. Signature of Fu	Service Licens	see											ral Home	
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Σ	only one) 3 29b. Signature and		se Practitioner: To the	e best of m	y knowled		curred at to oc. License		e and plac	ce, and due to		e(s) and man ate signed (N			
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	122		30. Name and addr	ess of person who	completed cause of de	eath (Item	23a) (Typ	e, Print)	445	Defe	nge	, High	100	ay	1	+	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Gwendolyn Joyce McLaughlin 2012 38452 Certificate of Death Registrar Reg. No 1, Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death Month Day October 28, 2012 Medical Examiner Gwendolyn J. McLaughlin 1050 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1090 Woodlawn Avenue Pasadena Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director Hours Jan 19 1945 damy1and 239-70-8127 67 1 M 2 X F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ö 1090 Woodlawn Avenue USA 21122 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, item 27 is marked other than "natural", or items traumatic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: **Black** Ś 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th M & T Bank 0 Bank Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Hubert Bovkin Josephine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dellare' McLaughlin(Daughter) 871 Turf Valley Dr. Pasadena, Md.21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 11-15-12 Annapolis, Md. Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22 Whane anti-deese Facility Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Exami Due to (or as a consequence of): events resulting in death) Last and - transit n/Medical attending physician or use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the use as t Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Physician past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed this certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed . death? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes ٩ 2 No After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural death. 1 Yes 2 No 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) within 24 hours at To the Funeral I completely filled determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 29, 2012 Veli 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

Amend #6 per F1 AAGO Health Dep		11-15-12 KA	H Please	e Type or Pr end items State of N	int in I	Black II	ndelib	le Inl	k. Ens	ure A	II Copie	es Aı	re Leg	ible.	
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, L.E	۾	11. Marital Status 1 Never Marri 3 Widowed		12. Was Decedent Armed Forces? 1 Yes 242 If Yes, Give Year or Dates.	Ever in U.S.	Į,	Vas Decede Yes, speci	fy Cuba	n, Mexican	gin? (Spec	cify Yes or No- Rican, etc.)	-	14. Race	- Americar	
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Baltimore, permit. Page 1 and Department of Hea mportant: If item any injury or other		20a. Method of Dispo	osition	Bemoval from State	ce.	ace of Dispos metery, crem	sition (Name atory or oth	e of ner place	e)	D	ate	20c. l	Location - (City or Town	n, State
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Physician/		Immediate Cause (F disease or condition	inal	one cause on each line	e. • 1	ede		۵۸			espiratory ar			lr lr	pproximate nterval Between Inset and Death
Medical Examiner		resulting in death)	ſ	Due to (or as	a conseque	ence of):	er Ci	، ذك:	1-1-10	ter-	terri	+01		_	10~18 LIW
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ords, P.C. v requires that been signed to should be det	<u>`</u>	Sept: L	a	ontributing to death b	ut not result	ting in the un	derlying ca	use give	en in Part I.		23e. Did to	,	1		cause of death?
Records, The law require cate has been signage 2 should 1									,		24a. Was autop perfo	sy rmed?	pri de	ere autopsy or to comp ath? Yes 2	findings available letion of cause of
Vital hysician: his certific	2	5. Was case referred examiner?	7	Hospital:	ent 2 🗆 E	R/Outpatient	3 🗆 DOV	Other	e of Death		nly one)				
n of oding Ph. After the funeral			5 Pending	28a. Date of injur (Month, Day	y 28	8b. Time of injury	280	. Injury a work?	at	28	e 5 Resid			Specify)	
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should b		2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined		ry - At home . (Specify)	e, farm, stree	M t, factory, c		es 2□N		f. Location (S City or Tow	treet and	d Number (or Rural Ro	ute Number,
he Hospita in 24 hours he Funeral poletely filled	2	CHECK Z	Intention Exami	sician: To the best of one; On the basis of executioner: To the	amination ai	nd/or investig	ation in my	opinion	death acco	urrod at th	a tima data a	ad place	and director	Alan ancient	s) and manner stated.
To the within To the commendation		9b. Signature and iti	le of certifier		0	m n l		icense r				29d. Da	te signed (/	/lonth, Day,	
Alife !	3	3 4 -	40	ompleted cause of de	eath (Item 23	Ba) (Type, Pri	nt)				111		11/1/2		
State	3.	1. Date filed (Month,		32. Registra	r's Signature	S. 6	reca	e -	> T.	B 1	Itimo	10	, 1) 2	1201
Registrar DHMH 17 Rev 06-201	1		10V 07 2	UIZ Pense	m,	8. p	what								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23a., pt. 11, 25, 27, 28a-f, per me, g940 6-19-13 sm. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Anthony J. Merlino 1:55 A M Medical 201 <u>November</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Waldorf Charles <u>Morningside House at St. Charles</u> Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Months Hours Min. (Month, Day, Year) Director 099-05-8004 1 X M 2 D F 96 Yrs. Usual Residence of Decedent 9/22/1916 New York 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'19 Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Prince George's Upper Marlboro 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 20772 15705 Croom Airport Road USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1941-45 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health end Mental Hygiene. item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 10 Supervisor Dairy Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angelo Merlino Mary Merlino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Merlino/Daughter 15705 Croom Airport Rd., Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) Date 20c. Location - City or Town, State Department of Importent: If it eny Injury or o 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 h Other (Specify) Kalas Crematory 11-5-2012 Edgewater, Maryland 22. Name and Address of Facility George P. 2973 Solomons Island Rd., 21. Signature of Fune, Kalas Funeral Edgewater, MD 2973 Solomons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau, on each liv. Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tren APPROVED BY NIEDICAL E resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death 9 Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hip Fracture 9 Hospital or Attending Physician: The law requires 124 hours after death.
6 Funeral Director: After this certificate has been signed in by the funeral director, page 2 should lietely filled in by the funeral director, page 2 should. Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Iniury at 28d. Describe how injury 5 Pending injury work? 1 ☐ Yes 2 🛣 No 2 X Accident subject fell Investigation 6 Could not be 10-29-2012 unk 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State) 70 Village St. #205 4 Homicide Assisted Living Facility Waldorf,MD. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastination in my opinion death and place. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 2012 death (Item 23a) (Type, Print) UNE CENTER State Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 28, 2012 Martinez 3:08A John Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital Center Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) 140-60-7320 Director 1 X M 2 □ F 4/15/1961 Colorado should be filed within 72 hours arrest and Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f show a marked other than "hatural", or items 23a or 28a-f show are went, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Prince George's Clinton Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 USA 9211 Stuart Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Preparation permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other than yi injury or other traumatic event, the ODS. Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton, MD 20735 P.O. Box 206 Rickie Dove/Minister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Heritage Meml. Cemetery 11/7/2012 Cremation 3 Removal from State Waldorf, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatu 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a Part | Enter the diseas Part . Enter the disease or complications shock, or heart failure. List only one couse hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ unoma disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 2 No 1 Tes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death. the Funeral Director: After this npletely filled in by the funeral o 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 To the I 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tji 00055120

State

Registrar

31. Date filed (Month, Day, Year)

NOV 07 2012

Smk 310 Washing ba

of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar		epartment of Health a		iene _{eg. No.} 2012	38456
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last) Ronald	G.	Maurice	2. Date of Deat		3. Time of Death 12:34 P _M
-	Examir		4a. Facility Name (if not institution, give street and 3940 Bexley Place	d number)	4b. City, Town, or Location o Suitland	f Death	4c. County of Death Prince Geo	rge's
	Funeral Director		5. Social Security Number 045-24-5134 6. Sex 以及 M 2 l	7. Åge (In yrs. last birthda	Months Days Hours	8. Date of Birth (Month, Day, 03/05/1	Year) Count	ace (State or Foreign ry) e Island
	Maryland :8a-f show	rector	10a. State 10b. County Maryland Prince Geor	rge's Suitla			10	0d. Inside City Limits
	h with the ns 23a or 3 nust be no	Funeral Director	10e. Street and Number 3940 Bexley Pla	ıce	10f. Zip Code 20746	1	0g. Citizen of What Count USA	ry?
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fu	1 Never Married XX Married 1 FYe	Decedent Ever in U.S. ed Forces? Yes 2xxNo s, Give or Dates.	3. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes	jin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - America Black, White, e Specify: Whi	tc.
21215-0036	within 72 hou giene. er than "nat , the Medica	Completed by	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Colle 5+	ege (1-4 or 5+) (G	ecedent's Usual Occupation live kind of work done during most b. DO NOT use retired) Attorney	of working	16b. Kind of Business/Ind	
Maryland	uld be filed I Mental Hyg narked oth natic event	To Be	17. Father's Name (First, Middle, Last) Alvarez Maurice		Edna	r's Name (First, Middle, M P. Trudeau	u	
	and 2 sho Health and tem 27 is r		19a. Informant's Name/Relationship (Type, Print, Janine M. Johansen / I	aughter 10	ailing Address (Street and Number) 303 Armand Ct. sposition (Name of	Spotsylvania		22553
Baltimore,	nit. Page 1 bartment of bortant: If it injury or o		1 🛣 Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify) 21. Signature 5 Funeral Service Licensee	I from State cemetery, c	crematory or other place)	11/2/2012	Clinton, Mar	yland
Ä	permi Depar Impor any ir		1 HU hou		6160 Oxon Hill	Rd. Oxon Hil	ll, Maryland	20745
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.		WAXUVXI	2 12	Approximate Interval Between Onset and Death
	ate be executed hysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequence of): ue to (or as a consequence of):				
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death. Ya hours after death. Funeral pirector, there this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transities.	/Me	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
ds, P.O.	requires that the been signed by should be deta		Part II. Other significant conditions contributin	g to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tob	acco use contribute to the	e cause of death?
Records,	: The law re cate has be ; page 2 sh	Completed by				24a. Was an autops perform 1 🗆 Yes 2	y prior to con ned? death?	sy findings available inpletion of cause of
of Vital	ysician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X X No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpa	_ Other	h (Check only one)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
on of \	ath. r: After this	Certificate: T	27. Manner of Death 28a. 1 Natural 5 □ Pending 2 □ Accident Investigation	Date of injury (Month, Day, Year) 28b. Time injury	e of 28c. Injury at	28d. Describe how	nce 6 Other (Specify) w injury occurred	
Division	ital or Atte irs after de al Directo lled in by th			Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural I State)	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check 2 Medical Examiner: On the	ne basis of examination and/or in	oth occurred at the time, date and prestigation, in my opinion, death occurred at the time, date 29c. License number	curred at the time, date and e and place, and due to the	place, and due to the caus	se(s) and manner stated. ated.
	× + °		· Jan TI	anel m	D247	89 MD	11/1/2	012
	7	9	30. Name and address of person who completed	cause of death (Item 23a) (Typ	e, Print) David Isaac	s, Sto. (A	no som	65 Mb

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Place 11/9/12 amend #4s per MD FCHD TM 11/9/12 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOV 04^{Day} 201^{Year} ROLAND BERNARD MILLER 5:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery GENESIS HEALTH CARE ROCKVILLE ROCKVILLE ROCKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09/26/1918 **Funeral** 9. Birthplace (State or Foreign 135-12-9009 Director 1 M 2 D F 94 ÑJ Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY POOLESVILLE 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19701 BODMER AVE. 20837 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armfed Forces?
1 2 Yes 2 No 1940 Black, White, etc. þ 1 🗐 Never Married 2 🗆 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1945 Specify: WHITE 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUSINESS OWNER 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SERVICE STATION 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ORLIE M. CARPENTER FLOYD C. MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19701 BODMER AVE., POOLESVILLE, MD 20837 RONALD H. MILLER SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If Ite
any injury or otl
once. 1 🗆 Burial 2 🗗 Cremation 3 🗆 Removal from State STAUFFER CREMATORY 11/05/201 2 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature formeral Service Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death 6 HOURS a CONGESTIVE HEART FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 'Examiner ATRIAL FIBRILATION YR. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE LUNG DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No 1 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Brisn D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVI PASSI, MD 15245 SHADY GROVE RD., #130, ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011

State

Maryland 21215-0036

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #5 per FH G934 12/5/12 dk
State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October 29. 2012 Physician/ 7:30p James Lee Moore Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 606 Merridale Blvd. Mt. Airy Carrol1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 219-14-1 🖾 M 2 🗀 F 88 April 4,1924 Virginia Usual Residence of Dece permit. Paga 1 end 2 should ba filed within 72 hours efter daath with the Maryland Department of Haalth end Mentel Hygiena. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-f show amy injury or other treumatic event, the Medical Examinat must be notified at once. 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21771 606 Merridale Blvd. United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 🖾 Yes 2 🗆 No
If Yes, Give
Year or Dates. WWII 1 ☐ Never Married 2 😾 Married ģ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Inspector Montgomery County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Franklin Moore MAry Bell Doane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Merridale Blvd. Mt. Airy, Maryland 21771 Judy V. Moore / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery 11/3/2012 Mt. Airy, Maryland. 21. Signature of Femeral Service License 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HE ART FAILURE Pnysician/ disease or condition resulting in death) EARS Medical Due to (or as a consequence of): Examiner DISEASE CORONARY ARTERY YEAR-S Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ettending physicien and I for use as the buriat-transit The law requires that the deeth cartificate be executed HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year bean signed by the should be dateched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à DISE ASE 190 NEY Division of Vital Records, CHRONIC 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? MEWITUS DIABETES 24a. Was an urs eftar death. •ral Director: Aftar this certificate has filled in by tha funeral director, paga 2 autopsy performed 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5500 Nursing Home 5000 Nursing Home 5000 Nursing Home 5000 Nursing Home 6 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of To the Hospital or Attending Pl within 24 hours eftar death. To the Funeral Director: Aftar tt complately filled in by tha funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 00060764 omour, 2012 PY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS JOHNSON DR #ZIZ, FREDERICK MD MD 45 BRANISLAV -OMANIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 5 Registrar

12-08660

Thomas Anthony Malcotti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	C	Certificate of	Death	TIG IVICIT	iai i iygiciic	∠ U 1 Reg. No.	2 0040
Physici		Decedent's Name (First, Middle,Last)		· .	2. Date of Dea	ath	3. Time of Death		
ledical Exami	ner	Thomas Anthon		otti, J r.				Day Year er 15, 2012	0001 hrs
		4a. Facility Name (if not institution, give s Carroll Hospital Center	treet and number)	4	lb. City, Town, Westmins		of Death	4c. County of Deat	n
Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Ye	ear If Unde	r 24Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. Bir	thplace (State or
Director		181-60-4446	2 F 47	7 Yrs.	Months Da	ays Hours	A.Clan	Foreig	
ROY		10a. State 10b. County	10c C	City, Town or Locati	on				10d. Inside City Limits
Maryland 28a-f show 1 at once,	50	Maryland Carroll		Mt. Ai	ry				1 Yes 2 No
Maryl r 28a-	Director	10e. Street and Number			10f. Zip Code			log. Citizen of What Cou	ntry?
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hours after death with the Maryland natural", or items 23a or 28a-f sh Examicer must be ootified at once	Funeral	1 Never Married 2 X Married	Was Decedent Ever in Armed Forces? Yes 2 X No. No. 1	If Ye			in? (Specify Yes or No Puerto Rican, etc.)	0- 14. Race - Amer White, etc.	ican Indian, Black,
rs afte	þ	3 Widowed 4 Divorced If o	Dates		Yes 2 X N			Specify: Who	
61	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		s Usual Occup est of working li		ind of work done use retired)	16b. Kind of Business/	Industry
5-0036 led within 72 Hygiene other than "	mpl		4	Acco	untant			U.S. Go	overnment
ry 5 ₹ 5 41		17. Father's Name (First, Middle, Last)		—-!. <u></u>		18.Mother's	s Name (First, Middle,		
21215-0036 uld be filed within 7 Mental Hygiene marked other than c eveot, the Medic	o Be	Thomas A. Malcott: 19a. Informant's Name/Relationship (Type	L, Sr.	10h Mailing	Address (O)		y Kowal	LE -12	
MD 2 d 2 shou Ith and I n 27 is numatic	۲	Robin Malcotti / V		- 1				mber, City or Town, State	
of Health If item 2 If item 2		20a. Method of Disposition	20	b. Place of Disposit	tion (Name of c	emetery,	Date	20c. Location - City or	
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental 1 tant: If item 27 is marked or other traumatic eveot,		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	I	t. Mary's			November 20, 2012	Nanty Glo	Pennsylvania
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tri	Ш	21. Signature of Funeral Service Licensee	,	22. Na	ame and Addre	ss of Facility		Funeral Home	es. P.A.
Physician	-	23a. Part I. Enter the disease, or complica	tions that caused the dea	8 E	. Ridge	ville	Blvd. Mt.	. Airv. Mary	land 21771
/Medical		failure. List only one cause on each	ine,						Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	pertensive to (or as a consequence	e of):	reroric	Cardi	ovacsular	Disease	334
- Anna	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due	to (or as a consequence	n of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
uted nd ransit		events resulting in death) Last Due d.	to (or as a consequence	e of):					
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760, ficate be g physici	-	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr				===	23d. Date of delivery	
Box 687 re death certification the attending red for use as t	ciar	past 12 months?	Live birth Pregnant at time of	death	al death 3 er (Specify)	Ectopic	pregnancy	Month E	Pay Year
BO ne deat the at red for	Physician		Unknown	0					
Vital Records, P.O. Box 68' bysiciao: The law requires that the death certify this certificate has been signed by the attending I director, page 2 should be detached for use as I director,	ρ	Part II. Other significant conditions co	ntributing to death but no	t resulting in the ur	iderlying cause	given in Par		obacco use contribute to	
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Vita ysicia his cer direct	o Be		ital: 1 Inpatient 2	✓ ER/Outpatient				Residence 6 Other	
iog Ph	\vdash_1	27. Manner of Death	28a. Date of tnjury (Month, Day,Year)	28b. Time of Inj	ury 28c. Inj	ury at Work?		now injury occurred	
Sion vitteod death. ctor: y the f	jatie	Natural 5 Pending Accident Investigation				Yes 2 1			
Division of Vital Records, P.O. pital or Atteodiog Physiciao: The law requires that th ours after death. teral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At (Specify)	home, farm, street	, factory, office	building, etc.	28f. Location (S or Town, S	Street and Number or Ruitate)	ral Route Number, City
	Medical	one) 2 Medicai Examiner: On	To the best of my knowle the basis of examination manner stated.	edge, death occurre	ed at the time, o	late and place	e, and due to the caus urred at the time, date	e(s) and manner as state and place, and due to the	ed. e cause(s)
FSFO	ž	29b. Signature and title of certifier			29c, Licen			29d. Date signed (Mor	th, Day, Year)
		Theola Mi	Kix The	u. D.	0.0	M.E. (/)	1 S - 100	November 15, 20	12
	ſ	 Name and address of person who com Theodore M. King, Jr., MD. 	oleted seuse of death (Ite Assistant Medical		00 W Balti	more Stra	et Baltimara ME	1 21223	
Sta	ite	31. Date filed (Month, Day Year)	32. Registrar's Signa		Ms. Baitil		et, pailimore, ML	/ L 1 L L L L	
Registr	-	NOV 1'9 201	2 General	13. Ag Co	Cheren				

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Gary Ernest Mayn	1- For State		State of	Maryla			tment of ificate of			Mental	Hyg		teg. No.	01	2 3846
Physician/ Medical Examine	1. Deceder Gal	4	t May									Date of Dea	ath	Year	3. Time of Death 1159 hrs
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Funeral Director		ecurity Number -66-7731	6. Sex	2_F		n yrs. Iasi 51	t birthday) Yrs.	If Unde Months	_	If Under 24	Hrs. {		irth(MM/DD/YY 4/1961	Forei	rthplace (State or 97Washington ountry) D.C.
the Maryland a or 28a-f show any tified at once. Director	10a. State	and Number	ontgor			c. City, T	own or Location		Code				10g. Citizen of		•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Me. Heal Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital 1 X Nev	ver Married 2	Married Divorced If	2. Was Dec Armed Fo Yes Yes, Give Year Dates:	edent Eve prces? 2 X	No ·	If Ye	s, specify Yes 2	t of Hispa Cuban, I		rto Rio	can, etc.)	Specit	ace - Amer hite, etc. fy: Wh	rican Indian, Black, nite
5-0036 lited within 72 hours Hygiene. 4 other than "natu the New First Exam Completed		dent's Education (S ary/Secondary (0- 12 s Name (First, Mid	12)	College (1		ted) 1			ing life. C ter	OO NOT use	retired)	16b. Kind of Home Maiden Surna	Cons	Struction
MD 21215 d 2 should be file in the and Mental H arth are marked numatic event, til	Aug 19a. Inform	stin Err nant's Name/Relati Dert Mayr	onship (Type								or Rur	al Route Nu	rgess mber, City or T sville,		
Baltimore, M cernit. Pages I and 2 Department of Health Important: If item 2 njury or other fraum	20a, Metho	od of Disposition ial 2 \(\sum_{\text{Crema}} \) Crema nation \(\sum_{\text{5}} \)	tion 3		om State	cre	ace of Dispositematory or other	ion (Nam er place)	e of ceme	etery,	D	ate L2/12	20c. Locatio	on - City o	Town, State
	21. Signatu	ire of Funeral Serv	ice Licensee							Bark	er Fu Layto	neral I	Home e, MI	20882	
Physician /Medical xaminer	failure Immediate or conditio Sequential if any, lead cause. En	Cause (Final disease) Cause (Final disease) resulting in death ly list conditions, sling to immediate ter Underlying Cau r injury that initiate	use on each ase a. He Due b. Hy Due	line. emorrh e to (or as a perte e to (or as a	agic conseque nsion conseque	Cer ence of): n Ca ence of):	ebral rdiova	Infa	rctio	on	ic or re	spiratory ar	est, snock, or	neart	Approximate Interval Between Onset and Death
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D. Box 68760, the death certificate by the attending physicsheld for use as the burnsheld for us	IF FEMALE 23b. Was d past 12	ecedent pregnant i 2 months? 2 No 9	n the Unknown	23c. If yes, of 1 Live bit 4 Pregnate 9 Unkno	irth ant at time		2 Feta	al death er (Speci		Ectopic pre	griancy		Month		Day Year
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1 of Vital R ing Physician: 1 After this certific funeral director, p on: To Be C.	25. Was ca examin 1 27. Manner	Yes 2 No	Hos	pital: 1 lr	npatient of Injury Dey,Year)		R/Outpatient 8b. Time of In	3 🗌 DO	DA O	at Work?	rsing F	one)	Residence 6	6 🗸 Othe	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune- edical Certification:	2 Acc	cident Ir	ending evestigation ould not be etermined	28e. Place (Specify)	e of Injury	- At hom	ne, farm, street	, factory,		s 2 No	28	f. Location (or Town, s		mber or Ri	ural Route Number, City
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W A S H S A	29b. Signature and title of certifier 29c. License number O.C.M.E. November 11								• • • • • • • • • • • • • • • • • • • •						
	Russ	ell Alexander I		sistant M	edical	Examir	ner 900 V	V. Balti	more S	treet, Bal	timor	e, MD 21	223		
State Registrar	31. Date fil	NOV 2 9 2	012 2	2 32. Re	pletrar's S	gnature	back								

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Kevin Michael Mo	1	- For State Registrar	State of	Maryla	and / E		rtment o tificate o			Mental H		Reg. N		12	38	+ 6
Physician	n/	Decedent's Name (First, Michael	idle,Last)						_		Date of De Month	ath Day	y Year	3.	Time of Death	
Medical Examin		Kevin Mich 4a. Facility Name (if not institu		Moran	ımher)			4h Cih	Town or l	ocation of Death	Novembe	er 14	, 2012 4c. County of De	eath	0839 hrs	
()		1271 Guadelupe Dr	. •	1000 and no	inder)				stminster				Carroll	·Qtiii		
Funeral	-	5. Social Security Number	6. Sex		7. Age (I	n yrs. Ia	st birthday)	If U	nder 1 Year	If Under 24Hrs	s. 8. Date of B	Birth(M	M/DD/YYYY) 9.		ace (State or	
Director		214-19-2270	ЖXМ	2 F	2	24	Yrs		nths Days	Hours Mir	Nov 2	24.		reign Countr	y) MD	
		Usual Residence of Decedent					_									
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21215-0036 Juld be filed within 7 Mental Hygiene, marked other than c event, the Medica		Frank D. Mo	ran.	Jr.						Cecel	ia Jenk	cins	3			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	힏	Frank D. Mo 19a. Informant's Name/Relation	nship (Type	e, Print)				-					, City or Town, S	tate, Zi	p Code)	
MD and 2 sho alth and 2 sho alth and alth and and 27 is		Patricia Mora 20a. Method of Disposition	n/Wife	e		T 205 E	519 F			St. Ha	nover,		17331 c. Location - City	, or To	um State	
Ore, es l an of Her If ite		1 K Burial 2 Cremat	ion 3	Removal f	rom State	c	rematory or o	ther pla	ace)							
Baltimore, permit. Pages Lar Jepartment of Hee, Important: If the		4 Donation 5 Other				Mea	dow Br				19/12		Westmins		_	
Balti permit. Departir Imports		21 Signature of Funeral Serv	certicense	2									L Home 8		apel, I !1157	PA.
Physician	┥	23a. Part I. Enter the disease,			caused the	e death.	Do not enter	the mod	Wasnin de of dying, s	such as cardiac	or respiratory a	rrest,	ster, MI shock, or heart	1	Approximate Inf	
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6876 certificate nding phy se as the b	an/	23b. Was decedent pregnant i past 12 months?		1 Live	birth nant at tim	ne of de	-44	etal dea		Ectopic pregn	ancy		Month	Day	Year	•
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Division sopital or Atteodii hours after death. neeral Director: A	cati	= J_P	ending vestigation		11-14				<u> </u>				et and Number o	r Rural	Route Number	City
Divi	Natural 5 Pending Investigation Fd 11-14-12 fd 6:10 am 1 Yes 2 No Unknown									, State	1271 Gu					
	To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only)									stated.						
To the I within 2 To the I complete	Medical		xaminar:0		of examir								place, and due		ause(s)	
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		30. Name and address of per						000	\A/ Delli	oro Street	Baltimera !	MD	1223			
		Patricia Aronica-Po		_	tant Me Registrar's				vv. Daitim	nore Street,		1410 2	. 1223			
Sta Registi	ate rar	31. Date filed (Month, Day, Ye	2012	100	KAL S	1.	are par									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Emma Beatrice Marsteller a/k/a Beatrice P. Marsteller 1:00 pM Nov. 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1706 Walker Road Freeland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. Maryland Months Days Hours 1 □ M 2 🖾 F 71 213-38-8234 Feb. 24, 1941 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Freeland MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21053 U.S.A. 1706 Walker Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Planter Plant Nursery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hurley Powers Nancy Collins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important; if Item 27 is any Injury or other trau once. Robert F. Marsteller Sr/Husband 1706 Walker Rd. Freeland, MD 21053 20b. Place of Disposition (Name of Pfile Crove Unity) Methodist Cem. 20a. Method of Disposition 20c. Location - City or Town, State Noverte 13. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 2012 Parkton, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 4/ Second St., New Freedom, PA 17349 ke 24 Ν. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 4145 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ. 4 Unknown icate has been signal, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ne Hospital or Attending 24 hours after death.

The Funeral Director: A pletely filled in by the fo 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2012 and address of person who completed cause of death (Item 23a) (Type, Print)

17W

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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201

DHMH 17 Rev 1/2001

72

South Grane St.

Bolkimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician/ DORIS MOZELLE MORRIS 2012 5:30A VON Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death LA PLATA CHARLES CIVISTA MEDICAL CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) 8. Date of Birth Months Days Hours Min (Month, Day, Year) 578-46-0152 Director 1 M M XX NOV.5,1936 76 WASH., DC show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 X No CHARLES FAULKNER 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9880 LOMAX ROAD 20632 S. Α. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give hours after Maryland 21215-0036 1 Yes 2X No Specify Specify: "natural", 3 Widowed 4 Divorced Completed WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) MEAT WRAPPER GIANT FOODS and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GEORGE W. DEBINDER MILDRED M. GAINES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 DEBORAH WHITE/DAUGHTER 9300 VIRGO ROAD, NEWBURG, MD 20664 or other Baltimore, 20a. Method of Disposition NOVEMBER 20b. Place of Disposition (Name of 20c. Location - City or Town, State of permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GRDNS. 19, 2012 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD M00641 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final "nysician/ RESPIRATORY FAILURE 1/6/2012 disease or condition Medical resulting in death) Examiner UNKNOWN METASTATIC PANCREATIC CANCER Sequentially list conditions Examine it any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed UNKNOWN METASTATIC LUNG CANCER and -trar Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No the 1 Yes 2 L 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? page death? certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🔀 No 1 Yes X Inpatient 2 - ER/Outpatient 3 - DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending injury 1 Yes 2 No within 24 hours after ueau...

To the Funeral Director: A 2 Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier **Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) D0026262

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of per

Date filed (Month, Day, Year,

20646

pleted cause of death (Item 232) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician/ Month 21:00 MARSHEAR MARSH OVERDES 7,2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER AIR HARFORD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Year) 234-08-5743 Director 1 🗆 M 2 🛛 F 49 12/2/1962 WEST VIRGINIA Usual Residence of Decedent 10b. County 10d. Inside City Limits or than "naturel", or items 23a or 28a-f sho 10c. City, Town or Location Director 1 X Yes 2 No HARFORD EDGEWOOD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 832 OLIVE BRANCH COURT 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 end 2 should be filed within 72 hours after of Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or any injury or other traumatic event, the Medical Evannin once. Š 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Completed 3 Widowed 4 WDivorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DIRECTOR OF ALUMNI AFFAIRS 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARVA HUGHES LOUIS L. LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 832 OLIVE BRANCH CT., EDGEWOOD, MD 21040 MARISHA D. MARSH/DAUGHTER Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 17, 2012 ROSEDALE CEMETERY MARTINSBURG, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, KING ST., MARTINSBURG, WV 25402 327 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine sequentially his conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physician end i for use es the burlai-transit requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) ed by the et deteched for 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 has funeral director, 25. Was case referred to medical Vital æ 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욛 1 Inpatient 2 I ER/Outpatient 3 I DOA this ð 27. Manner of Death 28a. Date of Injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) or Attending Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Division deeth. I Director: A Investigation To the Hospital or Atter within 24 hours efter ded To the Funeral Director completely filled in by th 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number November upper Che sapeake ause of death (Item 23a) (Type, Print) lan HOMPSON 32. Registrar's Signatur State Registrar

12-08626 Michael Grant Mc\	√eı		or Print in Blace of Maryland							ible.	1 V2	0015
	F	- For State tegistrar		Cer	tificate o	Death			Reg	g. No. 20	12	3846
Physician		1. Decedent's Name (First, Middle,L							ate of Death Nonth	Day Year 13, 2012		ime of Death
Medical Examine		Michael Grant 4a. Facility Name (if not institution, s				4b. City. To	wn, or Location o		ovember	13, 2012 4c. County of		.204 1113
	ı	946 Deer Park Road				•	minster			Carroll		
Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. la	ast birthday)	If Under			Date of Birth	h(MM/DD/YYYY)		ce (State or
Director		213-45-4666	K M 2 F	17	Yrs	Months	Days Hours	Min.	July 3	3, 1995	Foreign Country) MD
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ryland a-f sh u	흥	MD Carro	L.L	Wes		10f. Zip C	ode		10	g. Citizen of Wha		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Impurant: If item 27 is marked other than "natural", or items 23a or 28a-f shuw a injury or other trannaite event, the Medical Examiner must be notified at once.	Director	639 Wilmot Ridge	e Rd.			211				U.S.A .	•	
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5-0 led wii		17. Father's Name (First, Middle, La	ist)				18. Mother	s Name (Fir	st, Middle, M	laiden Surname)		
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D 2 Shoulk and M and M	ĺ	19a. Informant's Name/Relationship Mr. and Mrs. Jai										
my MD and 2 sho lealth and tem 27 is traumati	ŀ	20a. Method of Disposition			Place of Dispo	sition (Name			ite	ster, MD 20c. Location - C		
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Baltimore, permit. Pages I ar Department of Hee Importante: If ite	ŀ	4 Donation 5 Other Speci 21. Signature of Funeral Service Lice	ensee	De	er Park	Name and A						hapel, P
Depri	1	Mars Do			41	2 Was	hington	Rd. W	estmir	nster, M	D 211	
Physician		23a. Part I. Enter the disease, or co failure. List only one cause on		the death	. Do not enter	he mode of	dying, such as ca	ardiac or res	piratory arre	est, shock, or hear	t A	pproximate Interva letween Onset and
- Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a Multiple Blunt F								_	Death
	-		Due to (or as a conse	equence o	т):							
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e exercian a	<u>8</u>	UNPENDED	AMENDED									
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Box 68760, e death certificate by the attending physic ed for use as the bur	Physician/Medical E	past 12 months?	4 Pregnant at	time of de	noth =	etal death ther <i>(Speci</i>		pregnancy		World	Duy	1001
BO) e death the att	Jys.	1 Yes 2 No 9 Unkno	9 UNKNOWN									
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of Vital Records, P.O. og Physician: The law requires that the this certificate has been signed by uneral director, page 2 should be detacted.	8	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2	ER/Outpatier		Other	Nursing H		Residence 6	Other: Sc	ene
of V g Phys fter thi	읽	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Init	ULA	28b. Time of		Bc. Injury at Work	? 28	d. Describe h	now injury occurre	d	
on cading	틸	1 Natural 5 Pendin		(eer)	2142 hrs		1 Yes 2	No Pa	ssenger a	auto auto colli	sion	
Division tal or Attendi rs after death. al Director: A led in by the fu	ifica	2 ✓ Accident Investig 3 Suicide 6 Could I	not be 28e. Place of Ir	njury - At h	ome, farm, str	et, factory,	office building, et	c. 28				Route Number, City
Di spital cours a cral I	Certification:	4 Homicide determ	ined (Specify) Ma	•						itate) k Road, Westm)
		29a. Certifier (Check only one) Certifying Phy	sician: To the best of mer:On the basis of exa	ny knowled imination a	lge, death occi and/or investio	ation, in my	time, date and pla opinion, death oc	ice, and due	e to the caus e time, date :	e(s) and manner and du	as stated. le to the ca	iuse(s)
To t	Medical	29b. Signature and title of certifier	and manner stated.				License number			29d. Date signe		

31. Date filed (Month, Day, Year) NOV 2 9 2012 Registrar DHMH 17 Rev 1/2001 OCME 2006

Russell Alexander MD.

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

107C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

November 14, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	oartment of Health and N	Mental Hygiene	
1 - State Registrar			Registrar	ertificate of Death	Reg. No.	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year OCT 2012 3. Time of Death 740 M M M M M M M M M M M M M M M M M M	
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1 OCt 26 2012 1 P M 4c. County of Death	
	Examin	er	forest haven Nsq home	Catonsville	Baltimore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)	
	Director		219–34–4401 1 ⋅ M 2 □ F 73 Yrs.	World Suys Hours Will.	3/14/1939 MD	
	nd how at	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits	
	laryla 3a-f s iffied	Director	MD Carroll Westmins	ster	1 ☐ Yes 2 🙀 No	
	the N n or 28		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	ıs 23a nust k	Funeral	418 Baldwin Park Drive	21157	USA	
	death r item iner n		Armed Forces?	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.	
36	al", o	d b)	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Never Married 1 Never No. 1957— If Yes, Give 1966	1 ☐ Yes 2 🛣 No Specify:	Specify: white	
Ö	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Education 16a. Dec	cedent's Usual Occupation re kind of work done during most of work	16b. Kind of Business/Industry	
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auc	12 should be filed was and Mental Hyg 27 is marked other r traumatic event,	To E	John Clyde Naylor)	izabeth Horney	
Maryland 21215-0036	should and Me is mar aumati		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Run	al Route Number, City or Town, State, Zip Code)	
Σ̈́	and 2 si Health a tem 27 is		Janice M. Naylor, daughter 1449	9 Casa Grande Blvd.	, Fort Collins, CO 80526	
Baltimore,	e 1 ar t of He If iter or oth		4 D Buriel 2 E Cremetica 2 D Bernauel from State Cemetery, C	rematory or other place)	Date 20c. Location - City or Town, State	
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Ba	permit. Page 1 a Department of I Important: If it any injury or of		21. Signature of Funeral Service Licensee M00741	22. Name and Address of Facility Elj	ne Funeral Home , Hampstead, MD 21074	
		Н	23a. Part 1. Enter the disease, or complications that caused the death. Do not e		or respiratory arrest, Approximate	
أسادر	hystotian		shock, or heart failure. List only one couse on each line. Immediate Cause (Final Onset and Death Onset and D			
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876	ifficate ng phy as th	Med	IF FEMALE:			
9 ×	eath certificat attending ph I for use as th	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death	B Ectopic pregnancy	23d. Date of delivery Month Day Year	
B	e deat the at thed for	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 U Other (specify)	World Say (Gal	
P.O. Box 687	requires that the des been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?	
s,	uires t n sign uld be	ed by	HUPEKTENSION		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ IJnknown	
Division of Vital Records,	w requ	Completed			24a. Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of	
Rec	To the Hospital or Attending Physician: The law requires that the death certificate be executed within L4 Hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Som			performed? death? 1 Yes 2 No 1 Yes 2 No	
ta		Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)	
Ž		1	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa 27. Manner of Death 28a. Date of injury 28b. Time	tient 3 ☐ DOA 4 ☑ Nursing H	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred	
0 0		cate	Natural 5 Pending (Month, Day, Year) injur		200. Beschibe flow injury accounted	
<u> </u>		Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
<u>≥</u>		ledical Ce				
			29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or in	estigation, in my opinion, death occurred a	it the time, date and place, and due to the cause(s) and manner stated.	
	o the	Š	only one) 3 Certifying Nurse Practitioner: To the best of my knowled 29b. Signature and title of certifier	lge, death occurred at the time, date and pl 29c. License number	ace, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)	
0	L OU C		Lasneey Lack am no	Dassas-	10/30/12	
	40C		30. Name and address of person who completed cause of death (Item 23a) (Typ	ę, Print)		
	3+11		TASNEEM LAKHAMI, MY P.O.F.	DOX 1525 DWING	5 MILL MD JUIT	
State 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature Registrar NOV 0 1 2012						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Naylor 6:29AM ennis ot Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death of Maryland Baltimore University If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 578-76-8924 **Director** 1**X** M 2 □ F 57 Aug. 23, 1955 Washington, D.C. Usual Residence of Dece or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director Hagerstown 1 XX Yes 2 No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral United States 21742 20316 The Gardens, #203 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, th and Mental Hygiene.
77 is marked other than "natural", or ite traumatic event, the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2XX No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Development Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vera Stuart Charles Eugene Naylor, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20316 The Gardens, #203, Hagerstown, MD 21742 Catherine M. Naylor / Wife Department of Health Important: If item 2' any injury or other tonce. 20b. Place of Disposition (Name of 20c. Location - City or Town, State cerretery crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Nov. 2012 4 Donation 5 Other (Specify) Frederick, Maryland Memorial Gardens 21. Signature of Funeral Licer Resthaded Fufferal Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. 23a, Part 1. Enter the disease, or a shock, or heart failure. List of Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Medical Sephcemia disease or condition resulting in death) Due to (or as a consequence of) Examiner oneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? liver transplant 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DCA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending Accident Investigation after death Director, 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) g 4 Homicide determined within 24 hours after

To the Funeral Direct
completely filled in b Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1235438714 OCT 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Stephanos

32. Registrar's Signature

31. Date filed (Month, Day, Year)

NOV

Greene St. Baltimore MD 21201

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#29 poerMD, 11/8/12; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 1:20 a M Dolores Mary November Medical Petry 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Home Hyattsville Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 133-20-1699 Hours (Month, Day, Year) Director 82 1 M 2 XF Yrs 2, 1930 Aug. New York Usual Residence of Deceder 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD P.G. Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 Queens Chapel Road 20782 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: SpecifyWhite 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72 th h and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Editor Research Institution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Thomas Catherine Burgun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any njury or other trau Elizabeth Ann Bianchi/Sister 62 Crescent Road. Unit A. Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Nov 20<u>12</u> 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Signature of Funeral Service Licenses 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. MI 500 University Blvd. W. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Respiratory Failure Less than Medical Due to (or as a consequence of) mins Examiner Cardiac Arrest Less than Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): mins ng physician and e as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury Multi-Organ Failure that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Cancer Box 68760 <u>ess than</u> vear attending p IF FEMALE yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure to Thrive, Osteoporosis Records, cate has been sig r, page 2 should b 1 ☐ Yes 2 🛣 No 3 🗋 Probably 4 🖂 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 😾 No Yes of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🖾 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA this funeral 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #202 10810 Darnestown Road, Gaithersburg, MD 20878 Raman Tuli, MD

Registrar
DHMH 17 Rev 06-201

State

31. Date filed (Month, Day, Year)

08

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG-130 Seneca Dr Forest Heights
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country)

GRIFFIN GA 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 M 2 F 579-34-4468 Usual Residence of Decedent Yrs. Director permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Medical Evan in a cust for retitling at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 HYES 2 No Funeral Director ashington 10g. Citizen of What Country? 10e. Street and Number 1518 20019 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify Completed by If Yes Give BIACK 3 ₩idowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maken Dumestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MALY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forest Heightmd 20745 130 SeNECA Dr Woodn Rd, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LANdova Md 1+ARMin 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility The 140030 21. Signature of Funeral Service Licensee mo William 1182 814 485her ST. N.W. Washilder Zouil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ticemia disease or condition resulting in death) /Medical Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed nding physician and resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖫 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Practitioner To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Physician Medica Examine Funeral **Director**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medic Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial man Division of Vital Records, P.O. Box 68760

cal Certificate: To Be Completed by Physician/Medical Examiner
Med

•	1 - State Registrar		,	Certificat	e of D	eath			Reg. N	0.20	12	33	37
,	1. Decedent's Name (First, Middle, Las	st)						2. Date of D	eath)av	Year	3. Time of	Death
al		arra						Month Nove				6:00	P M_
r	4a. Facility Name (if not institution, give Suburban Hospita)				Town, or l		of Death		4	c. County Mont	of Death		
	5. Social Security Number 6. So		(In yrs. last birthd	ay) If Unde	r 1 Year	If Under		8. Date of Bi		Т	9. Birth	place (State o	r Foreign
		X M 2 □ F 75	Yn	Months s.	Days	Hours	Min.	(Month, D March			NY	ntry)	
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Dir	MD Montgom 10e. Street and Number	ery	Chevy	Chase 10f. Zip	o Code			-	10a. C	Citizen of V	What Cou		
Completed by Funeral Director	8001 Kerry Lane			20	0815				US			,	
Fun	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Dece	dent of His	panic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	-		e - Americk, White,	can Indian,	
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Be C		4	Bu	siness	Owne	r				Perso	ona1		
To B	17. Father's Name (First, Middle, Last) Albert Pisarra							e (First, Middle Front		n Surname	e)		
	19a. Informant's Name/Relationship (T)	ine Print)	105 1	4-11: 0 -1	- //					T C	N	Ondol	
	Barbara M. Pisarr		800	1 Kerr	y Lan	e, C	hevy	Chase	, MD	208	15	Code)	
	20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐	Damasus I frama Chaka	20b. Place of D	isposition (Nar crematory or c	ne of other place)		Date	20c.	Location -	City or To	own, State	
	4 ☐ Donation 5 ☐ Other (Specif	y)	Metropo	,	, ,		NO	v. 6 2012	A1	exand	ria,	VA	
	21. Signature of Funeral Service Licens	San San San San San San San San San San						Funeral				g, MD 2	20901
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	resulting in death)		consequence of):					$\overline{\cap}$					-
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cer illicate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	(Specify)		y, office			28f. Location City or To	Street a wn, Stat	nd Numbe e) 800	er or Rura 1 Ke	Route Numb rry Lai 0815	er, ne,
	29a. Certifier 1 X Certifying Phys	sician: To the best of m		home ath occurred a	t the time	date and	place a			_			•
Medical	(Check 2 Medical Exami	ner: On the basis of example Practitioner: To the	amination and/or in	vestigation, in	my opinion	, death oo	curred at	the time, date	and plac	e, and due	to the ca	use(s) and mai	nner stated.
-	29b. Signature and title of certifier.	*		290	. License	number	, 1100			ate signed			
	kning				02	394	43		No	v. 4,	, 201	. 2	
	30. Name and address of person who can ship—Chun Lin, M	ompleted cause of dea D 8600	ath (Item 23a) (Typ 01d Geor	e, Print) ge town	Road	, В	ethe	sda, M	D 20	814			
	31. Date filed (Month, Day, Year) NOV 0 7 2012	2. Registrar	's Signature	while.									

State Registra

41

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Ralph Peterson		State of Maryland / Dep	artment of Hea	ilth and Mental F			2 3347
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	ertificate of Dea	<u>tn</u>		g. No.	
Pnysici Medical Exam					2. Date of Death Month October 29		3. Time of Death 1740 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City,	Town, or Location of Deat		4c. County of Deatt	l
		Good Samaritan Hospital		more			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Und Mont	der 1 Year If Under 24Hr ths Days Hours Mir		h (MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director		578-70-9557 1 M 2 F 59	Yrs.	Ilis Days Hours Will	["] Jan. 7,		ountry) DC
á		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location				10d Inside Oit I :
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Maryland 28a-f show any d at once.	cto	DC 10e. Street and Number		Washington P Code	110	g. Citizen of What Cou	
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director		132.				
with t	ᇛ	4712 5th Street NW 11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Deced	20011 lent of Hispanic Origin? (S	pecify Yes or No-	United S	tates ican Indian, Black,
leath ritem	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		ify Cuban, Mexican, Puerto		White, etc.	san malan, blass,
after o	by F	3 Widowed 4 Divorced If yes, Give Year or Date:	1 Yes	2X No specify:		Specify: Bla	ck
1215-0036 d be filed within 72 hours a lental Hygiene. arked other than "natural arwent, the Medical Examin		15. Decedent's Education (Specify only highest grade completed)		l Occupation (Give kind of orking life. DO NOT use ret		16b. Kind of Business/I	ndustry
16 n 72 h	Slet	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of we	orking life. DO NOT use rec	irea)		
withi withingiene.	Completed	12 th 17. Father's Name (First, Middle, Last)	Print	er Pressman		Private	
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	To B	Emery Peterson 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address	s (Street and Number or	artha L Rural Route Numb	ong per City or Town State	Zip Code)
Fages 1 and 2 shoument of Health and Name: Witem 27 is no or other traumatic	7	Loretta D. Peterson - Wife	The same	h Street SE			0019
e, MI I and 2 s Health a		20a. Method of Disposition 20b.	Place of Disposition (Na	me of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hec Important: If ite		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or other place	NOV	. 9,		
Baltimo permit. Page Department o Important:	0.19	21. Signature of Funeral Service Consee	Lee's Crema	atory Address of Facility St	2012 Tewart Fr	<u>Clinton.</u> uneral Home	Maryland Lnc.
E E B E		John h Slever M00560		Benning Road	NE Was	hington, DO	
Physician		23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	n. Do not enter the mode	of dying, such as cardiac of	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Hypothermia					Death
-vet ^d		or condition resulting in death) Due to (or as a consequence of	of):				
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	of):		-		
	틭	cause. Enter Underlying Cause (Disease or injury that initiated					
bed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of	of):				
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50, te be	Jed	IF FEMALE: 23c. If yes, outcome of preg					
Box 68760, e death certificate b the attending physical for use as the but	Z	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 Ectopic pregna	ncy	23d. Date of delivery Month D	ay Year
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the de	Physician/Me	Part II. Other significant conditions contributing to death but not r	anulting in the condent in	anna sina in Bada	200 Diddeh	acco use contribute to t	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	à	Ethanol Use	esciong in the underlying	g cause given in Part i.		2 No 3 Prob	
ords, w require s been sig	Completed	LUMIOT USE		-	24a. Was an		opsy findings available
COL	흴				autopsy perform	prior to co	ompletion of cause of
tal Rectant: The certificate ector, page	S				1 ✓ Yes 2	No 1 ✓ Ye	s 2 No
Division of Vital Records, lal or Attending Physician: The law requir s after death. al Director: After this certificate has been sited in by the funeral director, page 2 should I	Be	25. Was case referred to medical examiner?		26.Place of Death (Check of Donald Other Nursin			
Ing Physi Ing Physi After this funeral dir	의	1 Yes 2 No 1 Inpatient 2 Y 27. Manner of Death 28a. Date of Injury		OOA Ourel4 Nursin 28c, Injury at Work?		esidence 6 Other:	ject expose
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r Atte	icat	2 X Accident Investigation I 10-29-12			<u>arconor</u>		
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Sal	29a. Certifier 1 Certifylng Physician: To the best of my knowledge (Check only)	ge, death occurred at the				d
o the ithin i	ğ	one) 2 Medical Examiner: On the basis of examination a and manner stated.					
F 3 F 3	Medic	29b Signature and title of certifier	290	c. License number	1:	29d. Date signed (Mon.	th, Day, Year)
		66(1111N)		O.C.M.E.	ļ	October 31, 2012	
	ŀ	30. Name and address of person who completed cause of death (Item					
		Zabiullah Ali, M.D. Assistant Medical Examiner		e Street, Baltimore,	MD 21223		
Sta Regist	ate	31. Date filed (Moch Der Dag 2012 32 Jegistrar's Signatu	9. Sperker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10728/2012 EDWARD WARFIELD PARLETT 6:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 8476 DONCASTER RD. EASTON TALBOT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Director** 215-34-5371 1 X M 2 □ F 72 02/07/1940 BALTIMORE, MD in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD TALBOT EASTON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8476 DONCASTER RD. 21601 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🕅 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Specify: WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MEDICAL EQUIPMENT DISTRIBUTOR MEDICAL 1 and 2 should be filed v of Health and Mental Hyg item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ NOAH E. PARLETT GENEVIEVE WARFIELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOBBI MEREDITH PARLETT/WIFE 8476 DONCASTER RD. EASTON, MD 21601 Baltimore, 20b. Place of Disposition (Name of CHESAP EANERY CREMATEON Page 1 ō 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/31/2012 CENTER STEVENSVILLE, MD 21. Signature of Funeral Service Lice FENDOWSADOHELIFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that ca the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) BLADDER CANCET MONTHS Medical Due to (or as a consequence of) [']Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should been 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 X No 욘 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in manner as a stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier DOOG 6409 10-31-2012

Registrar

DHMH 17 Rev 06-2011

State

TEAL DRIVE, BASTON, MD

8221

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR.Q.WILLIAM GAI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D3 November 2ď12 Katherine Pecci W. 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil North East 21 Whitaker Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Min. Hours Director 87 126-14-0186 1925 Delaware Jan. 6. Usual Residence of Deceden 28a-f show 10b. County 10a, State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🎝 No Maryland Ceci] North East 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 Whitaker Avenue 21901 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 0 δ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White "natural", 3 Widowed 4XXDivorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Healthcare and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elliott Wiley Anna Mae (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Tracy Bamford/Daughter 18 Rolling Avenue, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 5 Donation 5 Other (Specify) Bridgeville Cemetery | 19, 2012 Bridgeville, Delaware 21. Signature of Juneral Service 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Examir ysician and e burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Bra Anei -Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery yes 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown Seizure Disorder 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Day, Year)

State Registrar

10

ardaine

31. Date filed (Month, Dely, Year)

lane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Da

rdaine 32. Registrar's Signature

68760

Box (

P.O.

Records,

Division of Vital

104 E. Cecil Ave.

North East, MD21901

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

DHMH 17 Rev 06-2011

Gaffar Syed,

31. Date filed (Month

M.D.

801 Toll House, Suite H4, Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ Month Year Polley 9:12 AM Jeneiveve 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Julia Manor Healthcare Center Haverstown Washington Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 1-2-1 930 Country) 220-42-6000 82 **Director** 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Washington Williamsport 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21795 12421 Cedar Ridge Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ŏ à 1
Never Married 2
Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🔀 No Specify. "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) residence Elementary/Secondary (0-12) College (1-4 or 5+) homemaker 8th grade 0 Be her's Name *(First, Middle, Last)* Norman Sylvester Hose 18. Mother's Name (First, Middle, Maiden Surname) Hazel Lucretia McAllister 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ester M. Jones sister 10814 Wilcox Dr. Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenlawn Cem. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Williamsport, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O. BOX 310 Clear Spring, MD 21722

23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final Immediate Cause (Final Onset and Death Physician/ autestua Tortestina Hem orchasse disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events pertensiv Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death ed by the af detached f Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown licer Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 Yes 2 No Yes 2 No after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 1 🔼 Natural 5 Pending 1 Yes 2 No Accident Investigation M To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP-333Mill Street, Hagerstown, MD 21740

State Registrar 32. Legistrar's Signature

12-08635	
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Nelson R. Pierce, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland	Department of He	ealth and Menta	al Hygiene

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euicai Examine		4a. Facility Name (if not institution,		L.	4	b. City, Town	n, or Location of		November	14, 2012 4c. County of	f Death	00041113
	ı	Shady Grove Hospital			Rockville Montgomery							
Funeral Director			Sex 7. Age		st birthday) 3 Yrs.	If Under 1 Months	Year If Under Days Hours	1	B. Date of Birth	(MM/DD/YYYY) 2, 1958	Foreign	
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ore, M ss 1 and 2 of Health of Fitem 2	- 1	20a. Method of Disposition 1 Burial 2 XXremation	3 Removal from State		Place of Disposi rematory or oth		f cemetery,	D	ate	20c. Location -	City or T	own, State
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Baltimore permit. Pages 1 Department of I Important: If		21. Sonature of Funeral Service To	MOO		Se	ame and Add	ress of Facilit	^y Phel Iope D	ps Fun rive	eral and WInchest	l Cre	emation VA 22601
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5876 rtifical ling ph		23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fet	al death	3 Ectopi	c pregnancy	4	Month	Da	ay Year
Box 687 e death certific the attending p ed for use as th	Pnysician/	1 Yes 2 No 9 Unkno	wn 9 Unknown	ime of dea	ath 5 Oth	er (Specify)						
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Division of Vital Records, tal or Attending Physician: The law require as after death. al Director: After this certificate has been signed in by the funeral director, page 2 should then the funeral or the factor.	<u> </u>	1 X Natural 5 Pending		ar)		1	Yes 2	. I		, ,		
ViSion Atterder der in by t	<u>ह</u>	2 Accident Investig 3 Suicide 6 Could n	28e Place of Init	ury - At ho	ome, farm, stree	t, factory, off	ice building, e	tc. 28			r or Rur	al Route Number, City
Spital Spital neurs a filled	Certification:	4 Homicide determi	ned (Specify)						or Town, St	ate		
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F 3 F 3	¥ -	29b. Signature and title of certifier	and the state of				cense number			29d. Date signe		
		Throdon W.	King JA	246	u, D	, 0	.C.M.E.	OGN	E	November	15, 20 ⁻	12
IW-0		30. Name and address of person when Theodore M. King, Jr., M.	//			900 W R	altimore St	reet. Balt	imore. MC	21223		
Sta	te	31. Date filed (Month, Day Year)										
Registra	ar	MATO	29:2	notice of	A. A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year 1805 Erma Louise Phillips Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) 220-40-0280 **Director** 89 Maryland Nov 5, 1923 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Boonsboro 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21713 U.S.A. 42 North Main Street within 72 hours after death n "natural", or item edical Examiner n Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 X No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates Dearmit. Page 1 and 2 should be filed within 72 thous. Department of Health and Mental Hygiene. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tra Moss Hattie Cochran Moss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Young Avenue Boonsboro, MD 21713 Gary Phillips / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Brownsville Heights 11/16/2012 Knoxville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, P Signature of Funeral Service Licer at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 or complia or heart failure. List only one c Immediate Cause (Final disease or condition Onset and Death Physician/ Unlinens Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital မ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA funeral (27. Manner of Death Bate of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work' eral Director: A 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month,

Keedysville, Maryland 21756

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Robert Guedenet, MD, 21 Wyand Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 10 2. Date of Death Charles Joseph Pusateri, Sr. 2012 11:45 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Emeritus at Westminster Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 219-26-7232 1 🛛 M 2 🗆 F 04/14/1939 MD Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Carroll 1 🗆 Yes 2 🔀 No New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3846 Sams Creek Road 21776 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 X Yes 2 \(\square\) No 1958-1 Never Married 2 Married 1 ☐ Yes 2X No Specify. If Yes, Give White 3 Widowed 4 X Divorced Year or Dates 1968 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Contractor construction/remodeling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis James Pusateri Josephine Hutson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Pusateri/son 343 Pollen Court, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) N Burial 2 ☐ Cremation 3 ☐ Removal from State Pipe Creek Cemetery 4 Donation 5 Other (Specify) 11/02/2012 | New Windsor, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Famitts Funeral Home and Chapel 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adenocarcinoma of the Lungs disease or condition 8 months resulting in death) Due to (or as a consequence of Due to (or as a consequence of): Due to (or as a consequence of)

Physician/ Medical **Examiner**

been signed by the attending physician and should be detached for use as the burial-tran

has

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I

filled in by the funeral director,

Medical

Physician/

Examiner

Funeral

Director

or 28a-f show notified at

ems 23a or r must be i

items

Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
Iant, If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mu

permit. Page 1 a
Department of H
Important: If ite
any injury or ott

Baltimore, Maryland 21215-0036

with

irector

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Funeral

þ

Completed

Be

ည

Medical

10a. State

MD

Certificate: To

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner þ Completed 25. Was case referred to medical Be 27. Manner of Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

examiner?

1 Yes

1 Natural

2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

only one) 29b. Signature and title of certific

29a. Certifier

Accident

2 **X** No

3

5 Pending

Investigation

determined

6 Could not be

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

28a. Date of injury (Month, Day, Year)

Pregnant at time of death

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3 Ectopic pregna 5 Other (specify) Ectopic pregnancy

М

28c. Injury at

work

D33576

1 Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery Month Day

1 Yes

Year

2 No

Assisted

Living

1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10/31/2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Sikorski, M.D., 912 Washington Road, Westminster, MD 21157

31. Date filed (Month, Day, Year) NOV 0 1



DHMH 17 Rev 06-2011

Registrar

To the Hospital nr Attending Physician: within 24 hours after death. To the Funeral

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

Assistant Medical Examiner

29c. License number

O.C.M.E.

back

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

2012

29b. Signature and title of certifier

Russell Alexander MD. 31. Date filed (Month, Day, Year)

NOV

29d. Date signed (Month. Day, Year)

November 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month November Arnie Putnam 2012 Wayne 8:04 p.m. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 45909 Church Drive <u>Great Mills</u> Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 320-30-5487 1 XM 2 □ F Yrs. 75 Illinois 2/22/1936 Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Expriner must be notified at 1 and 2 should be filed within 72 hours after death with the Marylend if Health end Mentel Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-1 shov 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45909 Church Drive 20634 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Midowed 4 ☐ Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Captain B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Arnie Wayne Putnam Beverly Jean Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana J. Moeller/Daughter Honeycutt Lane, Gloucester, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If Ite
any Injury or oth Date UNK 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Signature of Euneral Service Licensee
Michele Brinsfield M01652 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): use as the burlel-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. To the Hospital or Attending Programmer: within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burlel-transpace of the funeral director, page 2 should be detached for use as the burlel-transpace. Due to (or as a consequence of): Physician/Medical Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No. **Division of Vital** Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🕅 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 🗌 Pending work? 1 ☐ Yes 2 \square No Investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

12+1 Rmu State

Registrar
DHMH 17 Rev 06-2011

40900 Merchants Lane, Suite 205, Leonardtown,

MD

20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O.

32. Registrar's Signature

Schmidt,

Jennifer

31. Date filed (Month, Day, Year) NOV 1

ah Anne Perk	1-For State Certificate of Death	Hygiene 20	12 3348
Physician/ cal Examiner	1. Decedent's Name (First, Middle,Last) Deborah Anne Perkins	2. Date of Death Month Day Year November 13, 2012	3. Time of Death 1617 hrs
	4a. Facility Name (if not institution, give street and number) 3000 McComas Avenue 4b. City, Town, or Location of Deal Kensington	th 4c. County of Montgom	ery
Funeral Director	5. Social Security Number 578-84-6273 6. Sex 1. Months Days Hours Mi		9. Birthplace (State or gto Foreign Washing to Country)
Maryland 28a-f show any 1 at once.	Usual Residence of Decedent 10a. State MD 10b. County Montgomery 10c. City, Town or Location Kensington		10d. Inside City Limits 1 X Yes 2 No
the Maryland Sa or 28a-f sh otified at once	10e. Street and Number 3000 McComas Avenue 10f. Zip Code 20895	10g. Citizen of Wha	at Country?
Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho re other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once and other traumatic event, the Medical Examiner must be notified at once of the Topic of the Medical Examiner must be notified at once of the Topic of the Medical Examiner must be notified at once of the Medical Examiner must be notified at once of the Medical Examiner must be not the Medical Exa	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, Puerly Carlos Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (3 If Yes, specify Cuban, Mexican, Puerly Carlos Yes, Give Yeer or Dates)	to Rican, etc.) White, Specify:	Black
led within 72 hours after dygiene. the Medical Examiner Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 16a. Decedent's Usual Occupation (Give kind or during most of working life. DO NOT use re Computer Analyst	etired)	•
Suite be filed within 7 Mental Hygiene. Mental Hygiene. marked other than ic event, the Medical		ne (First, Middle, Maiden Surname) ie Ingram	
es I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other tit ther traumatic event, the Med To Be Comj	19a. Informant's Name/Relationship (Type, Print) Brittany Perkins (Daughter) 1431 Longfellow	r Rural Route Number - City or Jown Street NW Was	ត់ដាំ <u>កិច្ច</u>
permit. Pages I ar Department of Hei Important: If ite injury or other tr	20a. Method of Disposition 1	11/22/12 Belt	city or Town, State Sville Marylånd , NW Washing
hysician /Medi_al xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease Due to (or as a consequence of):	or respiratory arrest, shock, or hear	Approximate Interval Between Onset and Death
uted d ansit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.		
be executed sician and urial - trans	x UNPENDED ☐ AMENDED 23a, pt.II, 27, per me, g935 1-17-	-13 sm	
Hospital or Attending Physician: The law requires that the death certificate be executed hours after death. Functal Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial—traal Certification: To Be Completed by Physician/Medical	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of of Month	delive ry Day Year
signed by the be detached by Ply	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death? Probably 4 Unknown
yysician: The law requires that this certificate has been signed director, page 2 should be determed BBE Completed by	Morbid Obesity; Cellulitis	24a. Was an 24b. W autopsy pr perform <u>ed</u> ? de	Vere autopsy findings available rior to completion of cause of eath?
certificate rector, pag	25. Was case referred to medical 26.Place of Death (Chec		Yes 2 No
2 2 2 2 0	Tes 2 NO	sing Home 5 Residence 6	
This is the state of the state	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe how injury occurre	r u
E Hospital or Attending Physician: The law requires that the death certificate be 1.24 hours after death. 1.24 hours after death. 1.24 hours after death certificate has been signed by the attending physicietly filled in by the funeral director, page 2 should be detached for use as the burcal Certification: To Be Completed by Physician/Med	1 X Natural 5 Pending 2 Accident Investigation		

35M

State 31. Date filed (Month, Day Year

Melissa Brassell, MD

30. Name and address of person who completed cause of death (Item 23a)

32 Registrar's Signatu

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) November 14, 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ North 2/30 M Reginald Scott Parker 20/2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1219 Balboa Avenue 204 Prince George's Capitol Heights Social Security Number If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Min. 1 🔀 M 2 🗆 F Country) Wash 43 09/10/1969 578-08-5102 Director .D Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Md. Capitol Heights P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1219 Balboa Avenue Funeral # 204 20743 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc "natural", or þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify Black Completed 3 Widowed 4 N Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important; If item 27 is marked other than "naturany injury or other traumatic event, the Morthal any injury or other traumatic event, the Morthal 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) D.C.Public Schools years Behavioral Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter J. Parker, Sr. Ethel James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter J. Parker, Sr. / Father 209 Chatfield Street, Tignall, Georgia 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 11/13/12 Landover Maryland 21. Signature of Funeral Service Licer see 22. Name and Address of Facility ington & Sons Co., Inc. rall and CC0316 4925 Burroughs Ave., N.E., Washington, D.C. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Arterioscherotic Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabates Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 1 Yes or Attending Physician: of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending Division after death. Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20/2 35M who completed cause of death (Item 23a) (Type, Print)
wester 3001 Hospital 30. Name and address of person

Registrar DHMH 17 Rev 7/2009

State

Registrar's Signa

2018s

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1031 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center 6. Sex 7. Age (In vrs. last hirter-<u>Iniversitu</u> of Baltimore Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Director 219-80-4613 1 M 2 TF 43 AUG 29, 1969 Maryland Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is merked other then "naturel", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be neutified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland 1 Yes 2 No Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1360 West Pulaski Highway 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Pearl Martin Amos, Jr. Beulah M. Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirsten A. Wilson/Daughter 128 Inverness Drive, North East, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 16, 2012 West Chester, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Anoxic Deare daus Medical Due to (or as a consequence of) 8days Examiner cecel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence or) ettending physicien end for use as the burlei-transit b Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death.
b Hours after death.
certificate has been signed by the ettending physicien end that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year cete has been signed by the (page 2 should be detached) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DDA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifiss of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

22

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Putman Joby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** Western Maryland Health System Cumberland If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Director 226-62-7268 1 X M 2 🗆 F 65 Sept.27,1947 VA 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director be notified 1XXYes 2 No Hampshire WV Romney 10f. Zip Code the 10e. Street and Number 10q. Citizen of What Country? or Funeral with 23a 26757 675 Kuykendall Lane item 27 is marked other than "natural", or items 23 other traumatic event, the Medical Examiner must USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. or i 1 ☐ Yes 2 🗶 No If Yes, Give þ 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ၉ Claude Wilber Putman Virginia Catherine Barr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moneta, VA 24121 103 Wisper Ridge and 2 s Health a (daughter) Barbara Ekapp 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date ÷ 1 Burial 2 X Cremation 3 Removal from State o Important: If any injury or once, 11/12/12 Scarpelli FH PA Cresaptown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen COL 4 22. Name and Address of Facility McKee Funeral Home Inc. Augusta, WV 26704 P.O. Box 270 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, in any, leading to mime date cause. Enter Underlying Cause (Disease or injury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy been signed by the atter in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed' this certificate 1 Yes 2 No Yes 2 No Hospital or Attending Physician: ' 24 hours after death. Funeral Director, After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ER/Outpatient 3 DOA Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending by the f 2 ☐ Accident 3 ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-5-2012

Registrar DHMH 17 Rev 06-2011

State

Willowskook Road Cumberland MD - 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 9 2012

2

SOT 32. Registrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7 1 2

			For State Registrar	State of Mary		tificate of E			Reg. No.	112	35400
			Decedent's Name (First, Middle, Las	t)				2. Date of De	ath		3. Time of Death
	Physicia Medic		Andrew A. Reid					Month 10	27	2012	11:30 ^{PM}
Andrew Spart	Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. Cour	ty of Death	
- April 1			Bowie Health Cent			Bowie	L KALL day 04 Lba	T		nce Ge	
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birthpl	ace (State or Foreign ry)
	Director		224-30-7657 Usual Residence of Decedent	EM 2 L F 81	Yrs.			01/29/	1929	Vi	rginia
	and show	5	10a. State 10b. County	10c	. City, Town or Loc	cation			- 11:	10	d. Inside City Limits
	Manyli 8a-f tiffiec	Director	DC		Washingt	ton					1 🏝 Yes 2 □ No
	the l		10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Count	try?
	is 23	Funeral	5132 7th Street,	NE		20011			US	A	
	death item ner n		11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R B	ace - America lack, White, e	
36	vithin 72 hours after death with the Maryland liene. Ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 No If Yes, Give	1	☐ Yes 2 🛣 No	Specify:		Spec	ify:	
21215-0036	atura cal E	Completed	15. Decedent's E	Year or Dates.	16a, Deced	lent's Usual Occup	ation		16h Kind of	Bla Business/Ind	
15	an "n Medi	ם	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give I	kind of work done of NOT use retired)		king	Too. rand of	20011000,1110	
212	within 72 rgiene. ner than t, the Me		Elementary/Secondary (0-12)	2	C16	erk			Libra	ry of	Congress
	B F E) Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surna	me)	
yla	ould be fil nd Mental marked matic ev	욘	Admon Reid				Rebecc	a Skeet	er		
(O	C S S		19a. Informant's Name/Relationship (T)	/pe, Print)	1	ng Address (Street a					
6	1 and 2 s of Health item 27 other tra		Andrea Reid - Da 20a, Method of Disposition		4707 b. Place of Dispo	Halloran	Court_				
jor	ge 1 at of h		1 Burial 2 X Cremation 3	Removal from State	cemetery, cren	natory`or other plac		Date		n - City or To	
Baltimore,	it. Pa Intmer Intant Injury		4 Donation 5 Other (Specif			1n Cremat					
Ba	permit. Page 1 Department of Important: If it any injury or of			ney Cheat	tau 3	Name and Addres B401 B1ad	ensburg 1	Road B	rentwoo		20722
П			23a. Part 1. Enter the disease, of com- shock, or heart failure. List only o	plications that caused the one cause on each line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between
	hysician/		Immediate Cause (Final disease or condition	a Cancer of	Gastro	esphageal	Junction	n			Onset and Death
1	Medical Examiner	П	resulting in death)	Due to (or as a con	sequence of):						
1		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence of):					_	
	d d ansit	Examiner	Cause (Disease or injury that initiated events	C							
	cate be executed physician and is the burial-transit	<u> </u>	resulting in death) Last	Due to (or as a con	sequence of):						
200	te be nysici he bu	edical		d							
87	certifica anding pl use as t		IF FEMALE:	00. 16							
Box 68	th ce trend for us	ian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnand Other (specify)	у			Date of delive Month	ry Day Year
B	is that the death certific gned by the attending be detached for use a	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	eordeam 5 L	Other (specify)					
P.O.	that the ned by the detach		Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	tobacco use co	ntribute to th	e cause of death?
<u> S</u>	irres t sign	Completed by	Dementia					1 🗆	Yes 2 No	3 Prob	ably 4 🖺 Unknown
ord	Physician: The law requires this certificate has been signal director, page 2 should by	olete	Atrial Fibrillat	ion				24a. Was		o. Were autop	sy findings available npletion of cause of
Sec	The law ate has page 2	mo	Hypertension						ormed?	death?	
a	i cian: The certificate rector, pa <u>c</u>	Be C	25. Was case referred to medical examiner?			26. Pl	ace of Death (Chec				
₹	hysic nis ce Il dire	욘	1 Yes 2 X No		2 X ER/Outpatier		er: 4 🗌 Nursing H	ome 5 🗆 Res	dence 6 🗆 C	ther (Specify)	
Jol	ing Physician: n. After this certific funeral director,	ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Yea	28b. Time of injury	work	?	28d. Describe	how injury occi	urred	
ior	Attending or death. ector: After by the fune	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b		At home form str		Yes 2 □ No	296 Location	"Ptroot and Alum	abor or Puml	Route Number,
>	5 # # E	V	4 Homicide determined	building, etc. (Sp		eet, lactory, office		City or To		ibei or nurar	noute Nutribel,
	Hospital of 24 hours a Funeral Dietely filled	Medical	(Check 2 Medical Exam	sician: To the best of my k iner: On the basis of examin	nation and/or invest	tigation, in my opinio	on, death occurred	at the time, date	and place, and	due to the cau	ise(s) and manner stated.
	To the Hosp within 24 ho To the Fune completely f	Me	only one) 3 Certifying Nur-	se Practitioner: To the bes	t of my knowledge	, death occurred at t 29c. License		lace, and due to	the cause(s) an 29d. Date sig		
			1 Dans	Thutng e	_	D005	1437		117	02/201	12
	ipsm		30. Name and address of person who	completed cause of death	(Item 23a) (Type, F		· = ¬ - /			2-/-01	
	2.Xiv.f.		Okeowo Ibitoye,	MD 12200 At	nnapolis	Rd Suite	232 G1	ennda1e	, MD 2	20709	
	Sta Registr		31. Date filed (Month, Day, Year)	3. Registrar's S	ignature	Mal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan		irtment d tificate d			-	0. /	110	201.27
			Registrar 1. Decedent's Name (First, Middle	, Last)		061	lincate	n Deali	/	2. Date of De	Reg. No	116	3. Time of Death
	Physicia Medic		Marie Theresa	Rosado						Voyeni	res Day	2012	6:15PM
	Examin		4a. Facility Name (if not institution				4b. City, Tov	vn, or Locatio	on of Death			nty of Death	
	F		Doctors Commun: 5. Social Security Number		a1 7. Age (In yrs. la	st hirthday)	Lanha If Under 1		der 24 Hrs.	8. Date of Birl		ce Geo	orge's
	Funeral Director		132-22-7558	1 □ M 2 🖾 F	92	Yrs.	Months D	ays Hours		(Month, Da	y, Year)	Count	try)
	d now at	Ļ	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc	ation			sept.	21, 1920		x, New York Od. Inside City Limits
	arylan ia-fsh ified a	ecto	,	e George's	1 '	Carrol						- 1	1 ☒ Yes 2 ☐ No
	the M or 28 e not	Funeral Director	10e. Street and Number	deorge B	New	Carro	10f. Zip Co	de		T	10g. Citizen	of What Coun	try?
	n with	nera	8321 Stanwood S	Street				20	0784			USA	Δ
	death r item iner n		11. Marital Status 1 ☐ Never Married 2 ☐ Mari	12. Was Deced Armed Ford 1 Yes	lent Ever in U.S ces?		Vas Decedent Yes, specify	of Hispanic (Cuban, Mexic	Origin? (Spec can, Puerto F	ify Yes or No- lican, etc.)		ace - Americ lack, White, e	
036	s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	ed by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1	☐ Yes 2 5	No Spec	eify:		Spec	ify: V	√hite
5-0	2 hours aft "natural", edical Exal	plete		nt's Education st grade completed)		16a. Deced	ent's Usual O	ccupation	ost of workin	a	16b. Kind of	Business/Ind	dustry
12.1	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4	4 or 5+)	life. DO	NOT use ret	ired)			Own H	ome	
200	lled will Hygid other	Be	17. Father's Name (First, Middle, L	ast)		Tromen.		18. Mc	other's Name	(First, Middle,	Maiden Surna		
Vlan	1 and 2 should be filed within 72 hour f Heath and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical	ပ	Robert Miller	_				Emn	na Huml	bert			
Aar O	shoul and l		19a. Informant's Name/Relationsh	1 (3)							r, City or Town		
524 e, 1	and 2 Health tem 27 ther to		Victor Rosado , 20a. Method of Disposition	Son	20b. P	8321 lace of Dispos			1	New Car	rollto	n,MD n - City or To	
Rosado Morie Baltimore, Maryland 21215-0036	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Ce	emetery, creme of Hear	atory or other	r place)		/2012		*	ew York
altii	permit. F Departm Importal any injul	1	21. Signature of Funeral Service L		Juice		Name and A			/2012			ore Avenue
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	and the state of		23a. Part 1/Enter the disease, or shock, or heart failure. List of			n. Do not ente	r the mode of	dying, such	as cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
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876	tificate ng phys as the	Med	IF FEMALE:									-	
9 × 0	tth cer tttendi for use	ian/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No		ome of pregnar lirth 2 Feta ant at time of d	I death 3 🗌	Ectopic preg					Date of delive Month	ery Day Year
B	he des y the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unkno		eath 5 L	Other (specia	· · · · · · · · · · · · · · · · · · ·					
Division of Vital Records, P.O. Box 687	requires that the death certifica been signed by the attending pl should be detached for use as t	by P	Part II. Other significant condition	ns contributing to dea	ath but not resu	ulting in the u	nderlying caus	se given in Pa	art I.				e cause of death?
rds,	een się	eted	veep v	10	10010								pably 4 🗆 Unknown
oce	The law r ate has b page 2 s	Completed	pleural	effusion	•					24a. Was autor perfo	psy ormed?	prior to coi	osy findings available mpletion of cause of
E E	ician: The certificate rector, pag	Be Co	25. Was case referred to medical	ig.			2	6. Place of D	Death (Check	1 Yes	2 No	1 Yes	2 1 No
Vita	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆	ER/Outpatien	t 3 □ D0A	Other: 4 \square	Nursing Hon	ne 5 🗆 Resid	dence 6 \square C	ther (Specify))
n of	ding P. n. After t	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	9	f injury n, Day, Year)	28b. Time of injury		Injury at work? 1 Yes 2		8d. Describe h	now injury occ	urred	
Siol	Attendar deat	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	of Injury - At ho	me, farm, stre						nber or Rural	Route Number,
Div	tal or irs afte al Dire			J	g, etc. (Specify)				L.	City or Tov			
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t	Medical	(Check 2 L Medical E		s of examination	and/or invest	igation, in my	opinion, death	occurred at t	the time, date a	and place, and	due to the cau	use(s) and manner stated.
	To the I within 2 To the I comple	Ž	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner:	Io the best of m	ny knowledge,		d at the time, cense numbe			the cause(s) an 29d. Date sign		
	1		Pointen Fr	ahif	M	. P.		0434	46.		11	5.12	
	35M		30. Name and address of person	who completed cause	of death (Item	23a) (Type, P				1 - 1	4 0	(1.	16 40 2076
	Sta	9	ROINTAN F. 31. Date filed (Month, Day, Year)	RAHI-FA	gistrar's Signat	ur <u>a</u>	150 /	thapo.	h) Ro	ad Suit	4 200	, Glenb	ll MD 2076
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Country) Director 212-78-5203 1 ፟ M 2 ☐ F 23, 1945 66 Nov. Jamaica 27 is marked other than "natural", or itama 23a or 28a-f ahow traumatic avent, It e Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 Tyes 2 No Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3301 Royce Avenue 21215 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or Black, White, etc. 1 Never Married 2 Married δ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Jamaican American 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) il Hygiana. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mantal Hygian 7 is marked other th Electrical Engineer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Kenneth Jordan Reid Melgeta Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haalth tam 27 Stanford Reid - Son 4205 Fairfax Road Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 12. parmit, Paga 1 Dapartmant of important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Stopy temas M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ therose 0 120 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Due to for as a consequence of sloian and i burial-transit Cause (Disease or injury that initiated events that tha daath cartificata ba axecutad Due to (or as a consequence of) resulting in death) Last physician s tha burial Physician/Medicai Box 68760 attanding p usa as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Pregnant at time of death 5 Other (specify) Month signad by tha a d ba datachad f g Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown paga 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s after death,

Director: After this cartificate
d in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? 1 Tes 2 1 No Other: မ 1 V Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined fillad in City or Town, State) Medical Hoapitai 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune complataly f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the 29b. Signature and title of certifier 29c. License number 350 e and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

		Am	Please Type or Prinend #5, per Inf G942 8/13/1 State of N	nt in Blac	k Indelible In	k. Ensure A	II Copies A	re Legible.	
			State		entai Hygie	ne 2 N 2	38489		
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of L	Jeani	Reg. 2. Date of Death	. No U I L	2 Fine of Doub
	Physicia		Riaz Hussain Ra	na			Month NOV	Day Year	3. Time of Death
mrz.	Medic Examin		4a. Facility Name (if not institution, give street and number)	-1.0	4b. City, Town, o	r Location of Death	1400	4c. County of Deat	1111
-			Howard Country General	Hospit	al Colum	bia		Howard	<i>I</i>
	Funeral		5. Social Security Number 0508 6. Sex 7. Ac	e (In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes	1000	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	77	rs.			1935 I	ndia
	and show	ö	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Aaryla Ba-f s	Director	Maryland Howard	Clar	ksville				1 ☐ Yes 2 🗷 No
	the h		10e. Street and Number	1	10f. Zip Code		10g	. Citizen of What Co	untry?
	s 23	Funeral	6301 Trotter Road		210	29		U.S.A	•
	deeth item	E	11. Marital Status 12. Was Decedent Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spec an, Mexican, Puerto F	ify Yes or No- lican, etc.)	14. Race - Ame Black, White	
36	efter	d by	1 Never Married 2 Married 1 Yes 2 If Yes, Give Yes or Dates	No	1 ☐ Yes 2 No	Specify:			slan
215-0036	72 hours efter deeth with the Maryland n "neturel", or items 23e or 28a-f sho Ascioni Examinet must be notified at	Completed	15. Decedent's Education	16a.	Decedent's Usual Occup	pation	161	b. Kind of Business/	
215	n 72 9. Ben "r	ള	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or :		(Give kind of work done o life. DO NOT use retired)	during most of workin	~ I	statistic	\ '
2	within yglene.		5+		Entrepren	reur		Analy:	sis
pu	e filed Itel Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)		,	18. Mother's Name	(First, Middle, Maid	den Surname)	
Maryland	uld be filed Mentel merked constituted con	-	Latar Ali Khan			Mmeer	Jan		0.0023
Ma	2 shou Ith and 27 is m treum		19a. Informant's Name/Relationship (Type, Print)	1-0-4	Mailing Address (Street a			1 1	Code) 28122
-	Heel Heel tem		Dana Kind/ Executr 20a. Method of Disposition		B9 Green Disposition (Name of			c. Location - City or	
Baltimore,	0 <u></u>		1 → Burial 2 □ Cremation 3 → Removal from State 4 □ Donation 5 □ Other (Specify)	cemeter	y, crematory or other place	e) Nover	yber -	isalaba	ا د د د
alti	permit. Page Department Importent: I eny injury o		21. Signature of Funeral Service Licensee	12 artar	22. Name and Address		A 1	m Funera	Services
m	Depart Depart Impo eny ir		No A	1	1242 Eas	y Street	, Wood		A 22191
			23a. Part 1. Enter the disease, or complications that cause shock, or beart failure. List only one cause on each lin	the death. Do no	ot enter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition	rdiane.	nic shor	k			Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as	a consequente o	ŋ:	1	N.		
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	ted insit	Examiner	cause. Enter Underlying Cause (Disease or injury	OA O	actori	disease	J		
	executed an end riel-transit	E	that initiated events resulting in death) Last C. Due to (or as	a consequence o	n: 0 199	01.0000			
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Box 68760	tificet ng ph	₩ We	IF FEMALE:					T	
9 X	th cer ttendi	lan/	23b. Was decedent pregnant 23c. If yes, outcome 1 Live Birth	2 Fetal death	3 Ectopic pregnanc	су		23d. Date of del	The second of
B	The law requires that the deeth certificate be ate has been signed by the ettending physici page 2 should be detached for use as the bu	Physician/Medica	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	t time of death	5 Other (specify)	-		Month	Day Year
P.O.	at th		Part II. Other significant conditions contributing to death t	ut not resulting in	the underlying cause give	ven in Part I.	23e Did tobaco	co use contribute to	the cause of death?
S,	lres t sign	d by	Health Care As	ociate	& Preun	onia			robably 4 nknown
ord	v requ	Completed	End stone read	1 Dise	ease_		24a. Was an		opsy findings available
€c	The lew ate hes pege 2	É	Junge 1 3 de	1 003			autopsy performed	prior to death?	completion of cause of
a F	iclen: The certificate rector, peg		25. Was case referred to medical		26. PI	ace of Death (Check	1 🗌 Yes 2 🕻	No 1 ∐ Yes	2 No
₹	hysic li direc		examiner? 1 Yes 2 No Hospital: 1 Patients	ent 2 ER/Out	patient 3 DOA Othe	er: 4 Nursing Hon	ne 5 Residence	e 6 Other (Speci	ify)
ō	Attending Physicien: r death. sctor: After this certific by the funeral director,	ate	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of inju (Month, Da)	ry 28b. Ti	jury work	?-	3d. Describe how in	njury occurred	
Ö	ttend death tor: A	Certificate:	2 Accident Investigation		M 1 🗆	Yes 2 ☐ No			
	affer Direc	Cer	4 Homicide determined 28e. Place of Inju- building, etc		m, street, factory, office	2	8f. Location (Street City or Town, St	t and Number or Rur tate)	al Route Number,
	To the Hospital or Attending Physiciem: within 24 hours after death To the Funerel Director. After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of	my knowledge, d	eath occurred at the time	e, date and place, and	due to the cause	s) and manner as sta	ated.
	he Ho in 24 he Fu pietel	Med	(Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practitioner: To the	xamination and/or	investigation, in my opinio	n, death occurred at t	he time, date and pl	ace, and due to the o	ause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	_	29c. License			Date signed (Month	
	107		March Dona	4)		5657		NON OF	+ 2012
	10 JM		30. Name and address of person who completed cause of d	eath (Item 23a) (T	1/	with Com	0-11	1 chia	am , lo
	Stat	e	31. Date filed (Month, Dan Year)	r's Signature	ward Loi	DO MAI	vau II	pro	Columbia,
	Registra	ar	NOV 0 3/ 2012 Francis	P. A	A COL	_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November I₄ 2012 12:35 PM Charles W. Richardson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cecil 402 Maryland Avenue E1kton 8. Date of Birth
Sept. 14,1931 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 F Days Hours Director 212-30-7539 81 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 United States 402 Delaware Avenue and Mental Hygiene. is marked other than "natural", or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Air 1XXXYes 2 \(\text{No Force} \) Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify Specify. 3 Widowed 4 Divorced Completed Year or Dates. 1951-54 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Car Inspector Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeff Richardson Edna West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 402 Delaware Avenue, Elkton, Maryland Sue Richardson / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November injury or 1 Burial 2 X Cremation 3 Removal from State Mayerdale Crematory 15, 2012 Newark, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Signature Fund relievice Lines 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland 21901 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performed? Yes 2 X No page death? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 2 Accident
3 Suicide Investigation M 1 Yes the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occ d at the time, date and plane, and due to the couse(s) and manner as states 29b. Signature and title of certifier 29c. License number D0062190 15 81 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ ICHAN MI)
25.33 AUGUSTINE HERMAN HWY, SVITE A, CHESAPEAISE CITY, MI) 21915

Registrar DHMH 17 Rev 7/2009

VA

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 5:52 a.mM Elizabeth Ingalls Ricketts November 6. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 579-36-9528 Director 1 □ M 2 F 02/03/1930 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show envingury or other treumetic event, the Medical Examiner must be indiffied at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20650 United States 40139 Combs Creek Way 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Agnes Marie Griffin Edgar Terry Ingalls 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40139 Combs Creek Way, Leonardtown, MD 20650 <u> Clifford Mackall Ricketts</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11/19/2012 Potomac, MD Signature of Fluneran Service Scensee Communication State of Michele Brinsfield M0165 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physic an/ disease or condition Medical resulting in death) o (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of if any leading to immediate cause. Enter Underlying ate has been signed by the ettending physician end page 2 should be detached for use as the burlel-trensit or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funerel Director: After this certificate i completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗆 Yes Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The Desire Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M treas 428

State Registrar

DHMH 17 Rev 06-2011

Rme

William D.

31. Date filed (Month, Day, Year) NOV 13

25365 Point Lookout Road, Leonardtown, MD

20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

M.D.

32. Registrar's Signature

Boyd II,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Grace Kathryn Rogers 2012 November 4:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Health & Rehab. Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 212-42-9594 Days Hours Director 1 🗆 M 2 🔀 F 97 Yrs. 12-22-1914 Maryland Usual Residence of Decedent end 2 should be filed within 72 hours efter death with the Maryland Health and Mental Hygiene. tem 27 is marked other then "netural", or items 23e or 28a-f show other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Shady Side Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4832 Woods Wharf Road 20764 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 11nk . ၉ William Lee Eliza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4832 Woods Wharf Road, Shady Side, Maryland 20764 <u> William Rogers /Son</u> Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State ematory or oth ò Lakemont Memorial Gardens 11-8-2012 injury o 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Itamia Immediate Cause (Final aerhac Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ned by the attending physician end e detached for use as the burial-transit The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ate has been signe page 2 should be Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 Tes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 3/1 No 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mannef of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Records, Hospitel or Attending Physician: 24 hours after death. Funerel Director: After this certifica etely filled in by the funeral director. of Vital Division completely

Registrar

29a. Certifier

(Check

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD GOOK

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Day 1 2012 LAURENA ELLEN REED 6:45A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 220-74-4766 1 □ M 2 🖾 F 54 Mar. 30, 1958 Maryland 28e-f ehow 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick 1 X Yes 2 ☐ No Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 301 Redwood Avenue 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 Married ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dispatcher City Government traumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be file of Health and Mental F I tem 27 is merked o മ Cletus Dale Jones Elsie Mae Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Reed / Son 301 Redwood Avenue Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 e
Depertment of H
Importent: If Ite
eny Injury or ot 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 2, 2012 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the dis-Part 1. Enter the discuss, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a construence of) Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificata be exacuted within 24 hours aftar daeth.

To the Funerel Director: Aftar this cartificata has baan signad by the attending physician and complataly fillad in by tha funaral director, page 2 should ba dstachad for use as the burlai-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy Were autopsy findings available prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 8 26. Place of Death (Check only one) examiner? Other: ၉ 1 ☐ Yes 2 📉 No 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗆 No Investigation 6 ☐ Could not be 3
Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1/1 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 68100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) US

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Leona Blevins Rash November 1334 РΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Healthcare Center Rising Sun Ceci1 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Hours Min. JAN 14. 1922 North Carolina **Director** 245-46-7561 90 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 👿 No Maryland E1kton Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2400 Blue Ball Road 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker <u>In Her Own Home</u> permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ McKinley Blevins Leofie McNeill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leta O'Neal/Daughter 2550 Grove Neck Road, Earleville, MD 21919 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Nottingham
Presbyterian Cemetery 20c. Location - City or Town, State November 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Colora, 12 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, Elkton, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-transi death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician Physician/Medical for use as yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death signed by the and be detached for significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? certificate 2 € To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of De Be examiner? 2 1 No ဂ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work's 1 Yes 2 🗆 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

State

and address of person who completed cause

Box 68760

Records,

Division of Vital

Registrar DHMH 17 Rev 7/2009 23 SINGERL

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ Month NOV. 9, Edith Marie Rentzell 7:52 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 219-50-3552 1 [] M 2 X F Yrs. July 13, 1916 96 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1707 Wilson Point Rd. 21220 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give à 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own HOme permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Importent: If item 27 is marked other any injury or other treumatic event, i Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Wandrer Edith Ludascher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Lynn Eachus/Niece 28 Cherry St. Phoenixville, PA 19460 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wester 1986 to we will ted Nov. Methodist Cem 2012 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JJ Hartenstein Mortuary, Inc. 24 N. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) UTERINE CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). attending physician and I for use as the burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physicien: The lew requires that the death certificate be 24 hours after death. • Funerai Director: After this certificate has been signed by the attending physicis 687 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Day 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) HOSPICE hours after death.

nerai Director: After this y filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar 29d. Date signed (Month, Day, Year) 2012 person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) NOV 2 9 2012

p.m.

2012

NOVEMBER

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Natember Physician/ RHOE EVELYN ٧. 10:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MERITUS MEDICAL CENTER WASHINGTON HAGERSTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 268-16-8955 Director 1 □ M 2 💢 F 94 4/10/1918 WEST VIRGINIA Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MARTINSBURG 1 🗆 Yes 2 🗔 No W۷ BERKELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumation." 25404 128 JENNINGS DRIVE APT 1A USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WHITE 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME **HOMEMAKER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar CARRIE BELLE RISER ည HERBERT ROY HESSLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 463 E. BALTIMORE ST., GREENCASTLE, PA 17225 SANDRA KINZER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State SNYDERS CEMETERY MORGAN CO., WV 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final set and Death Physician/ MULTIFOCAL INEUM ONIA disease or condition Medical resulting in death) Examiner FAILUR BNAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami WEEK Hospital or Attending Physician: The law requires that the death certificate be executed ANIMIA that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has lirector, page 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Matural Natural 5 Pending (Month, Day, Year) n 24 hours after death.

Le Funeral Director: Af oletely filled in by the fi 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number

5 Sh

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MT AGNA

(LOAI)

HAGENTOWN

WV

1190

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla	-			lental Hyg	jiene	1.0	00107
			State Registrar		Cer	tificate of De	eath		Reg. No.	12	3849/
	Physicia	n/	Decedent's Name (First, Middle, Las	st)	6	-/		Date of Dear Month	th Day	Year	3. Time of Death
. Orași Pari	Medic		4a. Facility Name (if not institution, give	street and number)	ر	4b. City, Town, or Lo	ocation of Death		4c. County	of Death	20:01
mark.	Examin	er	Shack Trauma	Center		211	ore-		10. 000111	y or boast	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yi	rs. last birthday)	If Under 1 Year I	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthp	lace (State or Foreign
	Director			□ M 2 🗓 F 83	Yrs.			Nov. 5,			Virginia
	nd thow at	'n	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation				1	0d. Inside City Limits
	faryla 8a-f s tified	rect	Maryland Montgom	ery	Gaither	sburg					1 X Yes 2 ☐ No
	the Na or 2	١	10e. Street and Number			10f. Zip Code	,		10g. Citizen of		
	within 72 hours after death with the Maryland giene. grent than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	Funeral Director	333 Russell Ave.			20877			United		
10	r deat or iten	by Fu	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	Rican, etc.)		ce - Americ ck, White, e	
036	s afte ral", c Exan	q pe	3 X Widowed 4 □ Divorced	1 Yes 2 X No If Yes, Give Year or Dates.	1	☐ Yes 2 X No	Specify:		Specify	Whi	ite
5-0	2 hour	Completed	15. Decedent's E (Specify only highest gr			ent's Usual Occupation		na	16b. Kind of E	Business/Ind	dustry
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d 2	iled within I Hygiene. other thai	മ	17. Father's Name (First, Middle, Last)				8. Mother's Name	e (First, Middle, I	Maiden Surnam	ne)	
lan	be filk ental rked c	T ₀	Andrew Kantor				Sophia 1			,	
Maryland 21215-0036	should be file n and Mental 7 is marked o raumatic eve		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	g Address (Street and	d Number or Rura	l Route Number,	City or Town,	State, Zip C	Code)
	nd 2 s ealth m 27			(Son)		Bell Towe		Gaithe			
Baltimore,	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State		natory or other place)		lo,	20c. Location Suitla		
Itim	it. Pag irtmen irtant: njury		4 Donation 5 Other (Speci	fy)		11 Cemeter	ry 20	12 o1 Fune:			
Ba	permit. Page 1 and 3 Department of Heall Important: If item 2 any injury or other		21. Signature of Funeral Service Licen	(M011)		0 East De					D 208770 M
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	Physician/		shock, or heart failure. List only of Immediate Cause (Final disease or condition		icato	ry for	Juro				Onset and Death
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	LAMITHE	-er	Sequentially list conditions,	b. trans	natic	brai	2 10	ury	-	1	15 days
	ed nsit	Examine	cause. Enter Underlying Cause (Disease or injury	fall	sequence of,.			1 1	el !	AL EXAMINER	
	n and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):			Let APP	ROVED BY ME		
90	iath certificate be executed attending physician and for use as the burial-transit	dical		d				DENTIFICATION APP			
687	rtificat ing ph e as tl	/Med	IF FEMALE:	00-16							
Вох 6	ath cea	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)				ate of delivionth	ery Day Year
	de he	Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown	or death o E	d other (opeciny)					
P.0	v requires that the s been signed by t should be detack	by Pt	Part II. Other significant conditions of	ontributing to death but not	t resulting in the u	inderlying cause giver	n in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
	juires en sign							1 🗆 ነ	res 2 No	3 Pro	bably 4 Unknown
of Vital Records,	has bee	Completed						24a. Was a	sy	prior to co	psy findings available mpletion of cause of
Rec	The la	Con						1 Yes	rmed? 2 X No	death?	2 🗆 No
tal	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	e of Death (Check				
Ţ	d is	1	1 X Yes 2 No 27. Manner of Death	1 N Inpatient 2	28b. Time of	nt 3 🗆 DOA	4 Nursing Ho	ome 5 Resid)
	Attending I ir death. sctor: After by the funer	cate	1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Yea	r) injury	work?	es 2 DYNo	Fall	, ,	ne	
Division	I or Attendii after death. Director: Af d in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined	De 28e Place of Injuny - A	At home, farm, str			28f. Location (S			Route Number,
Σ	ital or irs aftu al Dir lled in				HOP			Gaither	sburg.	MI	20978
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check 2 Medical Exam	rsician: To the best of my kinner: On the basis of examin	ation and/or inves	tigation, in my opinion,	, death occurred a	t the time, date a	nd place, and d	ue to the ca	use(s) and manner stated.
	To the I within 2 To the I comple	ž	only one) 3 L Certifying Nui 29b. Signature and title of certifier	rse Practitioner: To the best	t of my knowledge	, death occurred at the 29c. License r			ne cause(s) and 29d. Date sign		
	FSFO		> Esmor	voito		BA	6168	0/			
	17		30. Name and address of person who	completed cause of death ((Item 23a) (Type, I	Print)	- ,	- 1	,, ,		1012 7.1201
			Craig R. A	insword	Me,	MD 2	25 GR	eene si	Balty	werr,	1051 7 1201
	Sta Registr		31. Date filed (MoAth, Day, Year)	32. Registrar's Si	gnature day	del.					
	negistr	ar	NUV U O ZUI	Charles ,	CI. 149 484						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #10a-f Per INF G950 4/09/2014 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Adolphus Suydam 1620 Oct 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHeverly <u>Prince Georges Hospital</u> Prince Center Georges 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Year If Under 24 Hrs Hours Min. **Director** 579-74-0215 1 **X**M 2 □ F 57 12,1955 July Wash., DC or 28a-f show a notified at 10c. City, Town or Location **Lanham** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he matified as injury or other traumatic event, the Medical Examiner must he matified as 10b. Count 10a. State Funeral Director DC_MD Prince Georges 1 X Yes 2 ☐ No Washington, 10f. Zip Code 20706 10e. Street and Numbe 10g. Citizen of What Country? 5509 Oakbrook Place N.E. 20002 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 X Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Private Industry Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Adolphus Suydam Marquerite Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DeMarcus Suydam/Son 9947 #203,Lanham, <u>мр 20706</u> Good Luck RD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park 11/1/12 Harmony Mem. Landover, 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature uneral Service Licensee old 3821 14th Street, NW, Wash, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause are each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death -mysician/ fen Medical resulting in death) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter engerying Examine Due to (or as a consequence of) and -transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial attending physician For use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) 1 Live Birth
4 Pregnant :
9 Unknown Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy performe After this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ within 2 To the I only one) 29b. Signature and title of 29d, Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of cama 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 08 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health State of Maryland / Department of Health Registra MEND#23a(a)perMD, 11/8/12; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOVEMBER BEDENT SMITH 9:15 A M Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 239-05-1504 1 🔽 M 2 🗆 F 94 JUNE 25,1918 NORTH CAROLINA item 27 is marked other then "neturel", or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours efter death with the Maryland 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits MONTGOMERY 1 X Yes 2 No SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DAVID CT 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. \$ Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 🕅 Widowed 4 🗆 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRICAL ENGINEER U.S. POSTAL SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental If item 27 is marked ည WILLIAM BEDENT SMITH ELIZABETH HARRIET CHAPMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERGERON/WIFE 15556 PEACH LEAF LANE, NORTH POTOMAC, MD. 20878 COLLEEN 20a. Method of Disposition 20b. Place of Disposition (Name of Department of h Importent: If its eny Injury or ot once. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 11-8-2012 RIVERDALE, MD. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 2073 Chamberra M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration Pneumonia Immediate Cause (Final disease or condition resulting in death) Physician/ Onset and Death Medical Due to (or as a consequence of): Examiner 5 evert dusphasio Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). To the Hospitel or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and ecompletely filled in by the funeral director, page 2 should be a supposed by the attending physician and ecompletely filled in by the funeral director. igned by the attending physician and be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day g . Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown second 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy trav ormed? 2 🖸 No uvirary 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🖺 No ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D68315 Drive, pockerille, manjard 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical center Wer Cui MD 31. Date filed (Month, Day, Year) State 32 Registrar's Signature 08 NOV Registrar

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November

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 20°12 Helen Rita Sams 3:15pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bedford Court <u>Silver Spring</u> Montgomery **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under Months Days Hours 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😾 F 07-06-1915 Washington, DC 97 Director 577-09-2250 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Funeral Director 1 🗆 Yes 2 🙀 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 3701 International Drive 20906 United States filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l other than " College (1-4 or 5+) Elementary/Seconday (0-12) Secretary FAA/Bureau of Budget Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental H fitem 27 is marked ot r other traumatic even 2 Page 1 and 2 should be Ivan Ambrose Humphrey Agnes Bernadette Breen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret E. Arnn, Sister 2409 Sherbrooke Rd., Winter Park FL, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date - i - i 1 Burial 2 X Cremation 3 Removal from State Important: If any injury or once. Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11/9/2012 Glen Burnie, MD 22 Name and Address of Facility Thibadeau Mortuary Service, P.A. 7 Park Ave., Gaithersburg, MD 20877 Signature of Funeral Service Licensee M00956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death months Immediate Cause (Final Physician/ Failure to thrive disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events years Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🔀 No cate has been signed by the page 2 should be detached o ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? in 24 hours after town...

the Funeral Director: After this certifican moleted filled in by the funeral director, pe Yes 2 K No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗓 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of I or Attending P after death. 28d. Describe how injury occurred XNatural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Records, P.O. Box 68760 Division of Vital Hospital 6 To the Ho within 24 h. To the Fune.

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier

only one)

Dr. Nakul

31. Date filed (Month, Day, Year)

29b. Signature and title of confifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

¢bya1,

NOV 08 2012

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3801 International Drive#211, Silver Spring, MD 20906

29d, Date signed (Month, Day, Year,

November 7, 2012

29c. License number

D38457

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.